GTO STEP 1
NEEDS AND RESOURCES ASSESSMENT

What are the needs and conditions that must be addressed in your community or state to prevent sexual violence and/or intimate partner violence?

What resources are available in your community or state to help prevent intimate partner violence and/or sexual violence?

December 2006

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What is a Needs and Resources Assessment?

A **needs and resources assessment** [1] is a systematic process of gathering and critically interpreting information (data) about a particular health or social problem—such as **intimate partner violence** (IPV) and/or **sexual violence** (SV)—and the resources available to address such problems within a defined community or state.

The needs and resources you identify in GTO Step 1 will be the foundation of the rest of your planning, implementation, evaluation and sustainability process. This chapter will help your GTO Planning Team identify and prioritize problems within three areas to be addressed by your primary prevention plan:

1) Problems related to your **universal population**.
2) Problems related to your **selected population**(s).
3) Problems related to **prevention system capacity** in your state or community.

Assessing needs and resources requires information from a variety of sources and perspectives. Throughout this GTO manual such information is often referred to as **data**. Data generally come in two forms. **Quantitative data** are expressed as numbers or percentages, while **qualitative data** reflect the meaning or context of a situation, event or culture through words. Each form of data has its own strengths and limitations. Quantitative data are helpful because they can be used to make comparisons across groups and across time. Examples of quantitative data are the number and percentages of adults who have experienced a sexual assault in their lifetime as provided by the National Violence Against Women Survey results (Tjaden & Theonnes, 2006).

Qualitative data tell the stories behind the numbers and about the unique experiences or meanings people attribute to a given situation, event, or culture. They can enhance our understanding of questions such as, “why are certain forms of SV and/or IPV occurring in our community or state?”, or “why do certain population groups appear to be at higher risk of perpetrating or experiencing IPV and/or SV than other groups?” Examples of qualitative data are the recorded responses of community members to questions about IPV and/or SV asked during interviews or **focus groups**. A quality needs and resources assessment will include a balance of both quantitative and qualitative data to develop a fully informed picture of a given state’s or community’s resources and needs.

There are also many ways to collect data about IPV and/or SV such as reviewing existing databases, interviewing people, making observations of the environment, or administering surveys. Data can be gathered at the national, state, and/or local levels. It is critical that a needs and resources assessment be based on multiple sources of data. Existing research-based information is useful because it gives you valuable information that otherwise would require extensive time and resources to collect on your own. However, *community knowledge*[2] is also essential to fill in the gaps of what existing

[1] All terms in bold are defined in the glossary.
[2] Empowerment Evaluation principles are italicized throughout this manual to emphasize their importance and to illustrate how various GTO activities support the application of the principles.

research cannot tell you about your own community or state. Community knowledge provides the context within which data can be interpreted responsibly.

To be consistent with the **Empowerment Evaluation** (EE) principles of *improvement* and *capacity building,* needs and resources assessments should reflect a balance of both strengths and challenges associated with a given community or state. It can be easy to focus only on problems when doing a needs and resources assessment. Be sure to spend time considering the assets in your community or state. Knowing both the needs and the resources in your community or state is essential to setting your priorities for the rest of your planning process.

Why is a Needs and Resource Assessment important?
Each community and state is unique. While one community may be similar to another community in terms demographics, each community has its own history of addressing IPV and SV, as does each state. Additionally, similar demographics do not ensure that the same conditions (i.e. risk factors and protective factors) that are associated with IPV and SV are the same in demographically similar communities and states.

Communities and states are also constantly changing. The demographic composition, resources, and economic conditions of a community or state may be very different today than they were 10 years ago. The forces that lead to these changes may also be unique in each state.

Need and Resource Assessments allow communities and states to understand their unique IPV and SV-related needs and resources and how these needs and resources may change in the future. While some community or state stakeholders may 'know' the needs and resource of their community and state, three significant benefits of a comprehensive and inclusive needs and resource assessment process are that:

- Many more key stakeholders come to know the community's or state's needs and resources themselves
- Key stakeholders are able to develop a common understanding of the community's or state's needs and resources
- Key stakeholders are able to communicate with the broader community or state what the IPV and SV-related needs and resources are.

This GTO manual describes a process to develop a 5-8 year community or state plan for the primary prevention of IPV and/or SV. The first step in completing this plan is conducting a needs and resources assessment with a group of individuals who represent the diversity of the community or state. Thus, having an *inclusive* process is an important component of developing a needs and resources assessment. The plan emphasizes a 5-8 year time frame as progress in reducing SV and/or IPV will not be immediate. However, a 5-8 year plan allows a community or state to track and assess its efforts in reducing SV and/or IPV and in developing new resources to address these public health problems.

Why Needs and Resources Assessments are Important to the Primary Prevention of Sexual Violence and Intimate Partner Violence

Systematic needs and resources assessments provide the foundation for the rest of your planning process. The prevention of IPV and/or SV relies on your state or community understanding its specific needs and resources related to IPV and/or SV.

One reason to do a systematic needs and resources assessment is because your community or state is unique and is not identical to any other community or state. Although SV and IPV affect all states and communities, not all states or communities are equally affected. Each community and state has different needs and resources for the primary prevention of IPV and/or SV. Therefore, your prevention plan will be more relevant to you community or state if you balance *evidence-based* findings and *community knowledge* to understand the unique needs and resources in your own community or state.

Without the information found from a systematic needs and resources assessment, prevention plans are often based on the assumptions, beliefs, politics, and personal experiences of a few people who do not necessarily represent the community or state as a whole. To prevent this from happening, your GTO Planning Team should be *inclusive* and *democratic* and should collect data systematically from multiple data sources to determine the needs and resources within your community or state. By doing being inclusive, democratic and comprehensive, you will promote *accountability* to your community or state and full *community ownership* of your prevention planning process.

A benefit of doing a systematic needs and resources assessment is that it will make it easier to identify and select goals for your prevention plan (GTO Step 2) and to select appropriate strategies to reach those goals (GTO Step 3). In other words, identifing your priority needs and relevant resources will help you narrow and focus the rest of your planning process.

Needs and resources assessments are also useful as a **baseline** measure of your state/community before a new prevention strategy or capacity building activity begins. Later, after you implement your strategy, your GTO Planning Team can collect the same information again and compare the new data with the original baseline data from your needs and resources assessment. This comparison will show you how your state/community changed over time, possibly as a result of your prevention strategy.[3]

Finally, needs and resources assessments can foster *community ownership* and a sense of common purpose among the members of your GTO Planning Team. This is especially important if your planning team was recently formed. Working through a needs and resources assessment may also help orient and educate team members about new ways to think about IPV and SV with an eye towards primary prevention.

[3] Data collected before and after strategy implementation is also known as pre/post data.

Applying the Principles of Empowerment Evaluation (EE) to Your Needs and Resources Assessment

The 10 EE principles represent a philosophy of evaluation that is designed to increase the likelihood that communities or states achieve their mission or goals—in this case, to prevent first-time perpetration and victimization of SV and/or IPV. The 10 EE principles are presented in *Making a Difference: Empowerment Evaluation and Getting to Outcomes,* an introductory chapter to this manual.

Each of the 10 EE principles is relevant to every step of GTO. However, there are a few EE principles that are especially relevant to each step. For Step 1, the principles of *inclusion, community ownership, democratic participation, community knowledge,* and *evidence-based strategies* are particularly relevant when conducting a needs and resources assessment.

EE Principle	How the principle is applied to a needs and resources assessment:
Inclusion	Ensuring stakeholder representation and participation from a variety of sectors and levels when conducting your needs and resources assessment increases the authenticity of the process.
Community Ownership	The members of the needs and resources assessment work group, the larger GTO Planning Team, and the broader community or state should be invested in the process and outcome of the assessment.
Democratic Participation	Prioritizing the needs of your community/state requires making important decisions. Valuing voices equally and willingness to collaborate to determine the needs and resources in your community will strengthen buy-in and ownership of the remainder of your GTO planning process.
Community Knowledge	Communities have members who are highly knowledgeable about the problems of IPV and SV within their community and about what IPV and SV prevention work has happened in their community. Therefore, knowledgeable community members are a key resource for interpreting needs and resources assessment data. Information collected from focus groups and surveys are another way to capture community knowledge.
Evidence-Based Strategies	Needs and resources assessments also need to consider what has been learned about SV and/or IPV from scientific studies and research. Information from research can be used to make comparisons with your local or state data and to help interpret state and local information and knowledge.

Preparing for Your Needs and Resources Assessment

In the introductory chapter about GTO and Empowerment Evaluation, you were encouraged to form a GTO Planning Team to work through GTO as a group. GTO is most effective when it is done by an *inclusive* group of stakeholders who have *ownership* over the planning, implementation, evaluation, and sustainability process.

Assuming you have a GTO Planning Team, the members of your team come to this process with various professional and personal experiences and outlooks. Therefore, it is important to spend some time finding the common ground between the members of your team before moving forward. This section suggests several steps for preparing your GTO Planning Team for the work ahead and to help set the stage to apply the EE principles of *community ownership*, *community knowledge*, *capacity building,* and *organizational learning* as living, dynamic features of your GTO process. As you work through each step, you can record your group decisions on the *Needs and Resources Assessment Preparation Worksheet* on page 14.

Develop a Shared Definition and Understanding of Intimate Partner Violence and/or Sexual Violence

CDC's definitions of **sexual violence** and **intimate partner violence** were provided in the *Introduction to the Primary Prevention of IPV and SV from a Public Health Perspective*. These definitions can be a starting point for your GTO Planning Team to discuss the definitions of IPV and/or SV that the members of your team bring to your planning process. You want to know if there are differences in the way members of your team define and understand these problems so that these differences do not interfere with your process later. You may need to negotiate these differences until you arrive at a shared definition of these terms.

Develop a Shared Prevention Vision for Your GTO Planning Team

A **vision** can be defined as "a dream about what the future of your community or state will look like." Building a shared vision ensures that members of your GTO Planning Team share the same picture of the future and the same purpose of your planning process. Members of your GTO Planning Team may join your planning process with different priorities. The visioning process is an opportunity to surface those priorities and negotiate a shared set of priorities that represent the interests of the group and ideally, the community or state. If there are any pre-determined priorities for the planning process that are non-negotiable due on funding requirements (e.g., developing a plan that focuses on primary prevention as opposed to services for victims), those should be made known to all participants when they are invited to the join the GTO Planning Team.

Steps to Develop a Vision Statement

- Discuss the importance of a vision statement in the initial meetings of your group.
- Obtain "buy-in" from members about the need to have a vision statement.
- Finalize a timeline for developing the vision statement (don't let it go on too long).
- Determine the best ways to obtain personal visions from the members and/or key stakeholders in the community (e.g., discussion sessions, forums, and/or surveys).
- Obtain input from diverse groups of stakeholders.
- Determine how to collect the information and make sense of it.
- Draft an initial vision statement to be circulated to key stakeholders.
- Make changes based on input and share it again.
- Finalize the vision statement and share it with the broader community or state.
- Revisit the vision statement regularly, especially as needs and conditions change.

Sample Vision Statements for IPV and/or SV Primary Prevention

Sexual respect will be a foundation in our community's culture leading to the elimination of all forms of sexual violence.

Our state will have the capacity to plan, implement, evaluate and sustain primary prevention strategies that prevent the initial occurrence of IPV.

Form a Needs and Resources Assessment Work Group

Conducting a needs and resources assessment can be time and labor intensive. It can also be difficult to engage a large team in all of the steps of a needs and resources assessment. For these reasons, you may choose to identify a smaller group of key individuals from your GTO Planning Team to form a Needs and Resources Assessment Work Group to lead, plan, and conduct the needs and resources assessment process.[4] This group will probably need to meet more frequently than the full GTO Planning Team during the needs and resources assessment process. This Needs and Resources Assessment Work Group will report their findings back to the full GTO Planning Team. The full GTO Planning Team will then choose priorities based on the findings of the needs and resources assessment.

When seeking and selecting possible members of a Needs and Resources Assessment Work Group, try to select members who have one or more of the following characteristics:

- Skills and experiences that are relevant to needs and resources assessment such as prior experience working with data, experience conducting qualitative interviews and/or focus groups, critical thinking skills, evaluation skills, or willingness to develop these skills.
- Access to data through affiliation with universities, public health departments, police departments, local service providers, and/or medical professionals.
- Represent the perspectives of specific populations (i.e. survivors or under-served populations) that are present in your state or community. *Inclusion* of members representing the diversity within your community or state improves the group's ability to collect and interpret data relevant to these populations.
- Willingness and ability to contribute time.

Although welcome and helpful, researchers or professional evaluators do not have to be part of your workgroup. This GTO manual is designed so that it can be used by persons without formal research or evaluation experience. However, if you have the resources to work with an evaluator, an empowerment evaluator can help coach you through a needs and resources assessment.

[4] Some states and communities may not have enough GTO Planning Team members to create a separate Needs and Resources Assessment Work Group. In these cases, the GTO Planning Team should conduct the tasks in this chapter that are designated for the Needs and Resources Assessment Work Group.

Decide How Your Needs and Resources Assessment Work Group Will Work Together

Consider and make decisions about the following issues as a group to promote *community ownership* of the needs and resources assessment.

Past Experiences of Needs and Resources Assessment Work Group Members

One way to orient your Needs and Resources Assessment Work Group (NRWG) to the work ahead is to reflect on each team member's past experiences with needs and resources assessments. Think about how those past experiences may inform your current process. Some questions to ask to facilitate this discussion include:

- What are your group members' past experiences with needs and resources assessments?
- What did your group members find to be successful about their past experiences? What lessons did they learn that could be applied to your current assessment?
- How is the needs and resources assessment process outlined in GTO similar to and different from assessment models that group members have used in the past?
- What are your group members' past experiences working in groups to achieve a task? How big were the groups? How were tasks divided? How often did they meet?

Duration of Time for Needs and Resources Assessment

High quality needs and resources assessments can take up to a year to complete. Accordingly, your NRWG should consider devoting no less than 6-8 months to this task. You may want to spend more time if your community or state has never done a needs and resources assessment before for the primary prevention of IPV and/or SV. For those states and communities which have conducted previous assessments, the process outlined in this chapter can be utilized as method of 'checking your work,' and *improving* or updating previous assessments.

Roles and Responsibilities

Decide what the role of the Needs and Resources Assessment Work Group is compared to the GTO Planning Team, especially defining how much autonomy the NRWG will have. Next, decide how you will divide and share roles and responsibilities among members of your Needs and Resources Assessment Work Group. You should base these decisions on the skills and experience of the members of your team. You can record tasks for your needs and resources assessment on the *Needs and Resources Assessment Work Plan Worksheet* on page 16.

Frequency and Methods of Communication

You will need to decide how GTO Planning Team and Needs and Resources Assessment Work Group will meet and communicate with one another. Below are some of the questions you will need to address:

- How often will the Needs and Resources Assessment Work Group meet?
- How often will the GTO Planning Team meet?
- How will the Needs and Resources Assessment Work Group document and report its progress to the full GTO Planning Team?
- How will you ensure that priority needs are selected *democratically* and based on *community knowledge* both within the GTO Planning Team and the Needs and Resources Assessment Work Group?

In order to provide clarity and promote accountability, the answers to the above questions need to be written and distributed to all members of the GTO Planning Team and NRWG. Some GTO Planning Teams may prefer having the answers to these questions documented in meeting minutes. Other GTO Planning Teams may prefer a more formal Memorandum of Understanding (MOU) among Team members. The inclusive development of an agreement between the GTO Planning Team and the Needs and Resources Assessment Work Group promotes *accountability*, *community ownership*, *community knowledge*, *capacity building*, and *organizational learning*.

Define Your Geographic Area of Interest: Setting the Boundaries of Your Needs and Resources Assessment

Before you start your needs and resources assessment, your full GTO Planning Team should clearly define the geographic area that you will include in your assessment. Once you define the geographic area that you will focus on, everyone who lives in that geographic area will be the universal population of your needs assessment

If you are working at the state level your geographic area of interest is your entire state. If you are working at a community level, your geographic area of interest will most likely be defined in terms of a geographic boundary such as county or city limits, zip codes, school districts, socially defined neighborhoods, etc. Your GTO Planning Team and your Needs and Resources Assessment Work Group should include residents of the geographic area you choose.

Sometimes standard geographical boundaries are not the best way to define the scope of a needs and resources assessment. This may be true when social boundaries of a community do not correspond to official geographically defined categories such as census tracts, school districts, zip codes, or political wards. For example, Native American communities may be defined geographically by a reservation or territory that spans multiple counties and districts. Furthermore, some tribal members may not live on the reservation. In this case, you might want to include all members of the Tribe in your assessment regardless of whether or not they live on the reservation. Other examples include communities affected by highways and other forms of development that change access to resources across different parts of community that are geographically considered “one” community. For these reasons, it is good to be flexible and creative in the way you define your geographic area of interest.

Colleges and universities are another important consideration when defining your geographical area of interest. Student populations are generally not included in census information because they are not considered permanent residents of a community. If you want to include student populations, you will need to find demographic data from a source other than the census bureau. Colleges and universities often maintain their own records that would provide a community profile of the college and university, including crime statistics. Research tells us that SV and IPV occur at high rates on college campuses and that colleges and universities often have important resources and infrastructure that can be used in the effort to prevent IPV and/or SV perpetration and victimization.

If you are working at the state level…

A statewide needs and resources assessment should provide a picture of the state as a whole as well as the differences among regions/counties and demographic groups within the state. To do this, you should preserve data at the regional and county level for cross-region and county comparisons. This will allow you to identify areas with unique needs and selected populations within the state.

Needs and Resources Assessment Preparation Worksheet

Shared definition of intimate partner violence and/or sexual violence
Shared vision of IPV and/or SV prevention
Members of Needs and Resources Assessment Work Group (or GTO Planning Team if no separate work group)
Key lessons from past experiences conducting needs and resources assessment
Key lessons from past work group experiences

Needs and Resources Assessment Preparation Worksheet

Continued

How much time will you devote to your needs and resources assessment?
What is the role of the Needs and Resources Assessment Work Group in relation to the GTO Planning Team?
How will roles and responsibilities be shared and divided among members of the Needs and Resources Assessment Work Group?
How often will the Needs and Resources Assessment Work Group meet?
How often will the GTO Planning Team meet?
How will the Needs and Resources Assessment Work Group document and report its progress to the full GTO Planning Team?
How will you ensure that priority needs are selected *democratically* and based on *community knowledge* both within the GTO Planning Team and the Needs and Resources Assessment Work Group?
What is your GTO Planning Team's geographic area of interest?

Needs and Resources Assessment Work Plan Worksheet

Task	Who is responsible for this task?	By when?

Developing a Community or State Profile

Most communities and states in the United States have changed drastically over the past 30 years. Whether the changes are related to shifts in the economy or changes in the racial/ethnic composition of a community, one thing is for certain, states and communities are not static—rather, they are thriving systems that change and grow constantly. Changes in populations, economy, geography, and institutions can impact norms regarding IPV and/or SV, resources available to address SV and/or IPV, and the degree to which state and local institutions prioritize IPV and/or SV as public health problems. Therefore, the changing conditions that characterize a community or state can have a significant impact on the prevention of IPV and/or SV. The more your GTO Planning Team understands the changing conditions that characterize your community or state, the more prepared you will be to develop a prevention plan that fits and is able to adapt to the changing conditions and environment within your community or state.

A **community or state profile** is a way of describing what a community or state looked like in the past, what it looks like now, as well as what it might look like in the future based on existing trends. More specifically, community and state profiles describe the people who live in your community, conditions such as indicators of well-being of children and families in your community, and resources such as skills, organizations, funding, and community assets) of a community or state as they were in the *past*, as they are *currently*, and as they may be in the *future*.

The process of developing a community or state profile is a valuable growth opportunity for your Needs and Resources Assessment Work Group and your GTO Planning Team. The development of a community or state profile supports the EE principles of *community ownership, inclusion, democratic participation, social justice, community knowledge, capacity building and accountability*. The profile can be used as a tool to challenge assumptions that members of a team bring to the process and can facilitate a common understanding of the concerns and priorities within a community or state.

A community or state profile typically includes information about past, present and projected demographics and economic conditions.

Demographic Profile

- number of individuals and family households
- age distribution
- sex distribution
- marital status
- racial/ethnic composition, including acculturation status
- number of people with disabilities
- number of people who identify as gay, lesbian, transgendered or bisexual
- distribution of urban, rural, immigrant/refugee, and tribal populations
- educational attainment

Economic Profile

- annual household income
- major employers
- unemployment rates

Knowing who lives in your community or state will be a useful point of reference later on when you begin to examine data about IPV and/or SV in your community or state. Consider this example: A community learns from its community profile that 8% of its male population is between 18-24 years of age (based on U.S. Census data). Later, crime data reveal that 20% of male perpetrators charged with sexual violence crimes in the community were between the ages of 18-24. Without knowing the percentage of the male population that is between the ages of 18-24, the crime statistic is almost meaningless. However, since we know that only 8% of the community population is in that age group, that tells us that males in that age group are overrepresented in the crime data. Since the percentage of perpetrators in that age group is much larger than the percentage of the general population within that age group, it appears that individuals between the ages of 18-24 in this particular community are at greater risk for perpetrating IPV and/or SV than the general population. This finding is consistent with findings from many research studies. Depending on the other factors revealed by this community's needs and resources assessment, this community may identify males between the ages of 18-24 as one of their selected population(s).

Some NRWGs may have access to a community or state profile that was recently (i.e., within the past five year) completed by another organization, such as a Chamber of Commerce or Department of Commerce. NRWG members are encouraged to first review and analyze this community profile prior to expending their resources on developing another. A NRWG's analysis of an existing community profile would include an assessment of whether or not the existing profile comprehensively explored the community's or state's demographics and economic conditions. NRWG are encouraged to utilize any existing community profiles as a basis for the development of their community profile.

The more you know about the general composition of people and families living in your community or state and who are project to live there in the future, the more perspective you will have when you are ready to look at data about IPV and SV.

Before moving on to the next step, the Needs and Resources Assessment Work Group needs to ask "Who is missing from this profile?" Are the Lesbian, Gay, Bisexual, and Transgender populations, people with disabilities, youth, and immigrant/refugee populations adequately represented in this profile?

If you are working at the state level…

If you are assessing needs and resources across your entire state, you may want to develop separate profiles for each major region or county within your state, rather than a single profile for your whole state, particularly if your state is large or has regions or counties that are very different from each other. For example, you might want to create separate profiles for the state's major metropolitan regions and rural areas, or you might want to create profiles for different geographic regions within the state. Separate profiles can help you understand the differences between these areas and give you a more in depth picture of your state. If you develop separate regional or county profiles, make sure that when taken together, these profiles represent your entire state and not just selected regions.

A *State/Community Profile Tool* adapted from CDC's Planned Approach to Community Health (PATCH) is included in Appendix A (U.S. Department of Health and Human Services, n.d.). The tool can be used for either a local community profile or a state level profile. The profile tool provided is only a sample. You may adapt it to fit the information that is available for your state or local community. You may want to add additional items to your state/community profile or adapt the items provided.

Sources of Information about Population Demographics and Community/State Conditions

Information for a community profile can be obtained from the U.S. Census Bureau, state government, city and county agencies, the United Way and other service agencies. The following table describes several sources of data for a community or state profile along with some of the limitations of each data source.

Source	Website or Location	What You Can Learn from the Data	Limitations of the Data
U.S. Census Bureau	www.census.gov	Population and demographic statistics at national, state, regional and local levels. Allows comparison of local, state and national data.	A complete census is only taken every 10 years, although estimates and interim surveys are available each year. Some populations such as migrant workers, undocumented immigrants, and college students are not captured by the census.
Local Chambers of Commerce	Search for your county or city chamber of commerce website on the internet. Look for local demographic information on the website. Contact members of the Chamber directly to request more detailed information.	Local statistics about employment, income, and demographic information.	Varies by state/region.
Kids Count	www.aecf.org/kidscount/	National, state and local data about the status of children and families including benchmarks of child well-being and economic and family descriptors.	Limited availability of local level data.
Local studies and statistics	Check with your state or local United Way, regional planning council, and/or state/ local office that manages statistics in your state.	Information about issues such as health, community wellness indicators, injuries, poverty, homelessness, etc.	Varies by state/region.

After assessing the demographics of the state or community, the GTO Planning Team and the NRWG may want to reassess who is participating on the GTO Planning Team and the NRWG. The demographic profile may reveal that a certain group is not represented on the GTO Planning Team or NRWG although that group represents a significant or growing group within that state or community.

Resources and Assets as Part of a Community or State Profile

Resources and assets are an important component of a community or state profile. Knowing your resources will help you decide which problems or conditions to prioritize later in this chapter. By prioritizing problems that are not addressed by existing resources, you promote *social justice.* By building on existing resources you promote *improvement*. In addition, by knowing your resources, you can develop goals and strategies that complement rather than compete with existing resources or that strengthen the resources that already exist so that they are more useful in preventing IPV and/or SV.

Resources include organizations, relationships among organizations, processes (e.g., data collection activities), events (e.g, city council meetings), funding, skills, or knowledge in your community or state that can be used towards the primary prevention of SV and/or IPV. Existing resources are commonly underutilized, usually because people are not aware that they exist, do not know how to access the resources, or think that they are not eligible to use the resources. Resources can also be underutilized due to the relationships among organizations. These relationships can be cooperative, competitive, integrated or disparate. Understanding the relationships among organizations that provide resources can identify barriers and opportunities. A thorough resources assessment can help you tap into the assets in your community.

Asset mapping is one way to conduct a resource assessment. One of the most well-known models for asset mapping was developed by Kretzmann and McKnight, co-directors of The Assets-Based Community Development (ABCD) Institute (Kretzmann & McKnight, 1993). The ABCD approach to resource assessment focuses on three types of assets including (1) individuals, (2) informal local associations, (3) and formal institutions.

Individual level assets include gifts, skills, and capacities among community residents such as youth, the elderly, artists, and community volunteers. Kretzman and McKnight provide tools for gathering information about individual assets. You can find these tools on the website for the Assets-Based Community Development Institute at www.northwestern.edu/ipr/abcd.html.

Informal local associations include groups such as civic groups, charitable groups, youth clubs, and civic events. The formal institutions within a community or state include schools, churches, hospitals, colleges, parks, police stations, and libraries. Kretzmann and McKnight suggest using newspapers or other printed sources such as a phone book and talking to leaders at local institutions to learn about the existence of harder-to-find organizations in a community. A list of potential informal associations and formal institutions that you can search for in your state or community is provided below.

Potential Informal Associations and/or Formal Institutions as Partners in Preventing IPV and/or SV

- School-based & clinic-based health education
- Violence prevention & safety promotion initiatives, including battering intervention and sex offender programs
- HIV-AIDS prevention initiatives
- Teenage pregnancy prevention programs
- Alcohol and substance abuse prevention initiatives / coalitions
- Schools and Department of Education
- Sexuality education programs
- Gender equity initiatives
- Positive youth development initiatives
- Healthy communities and other community-based wellness initiatives
- Faith-based initiatives focused on gender equity or community non-violence
- Park and recreation departments
- Major Employers and Local Businesses
- Universities / colleges
- Service oriented sororities and fraternities
- Medical professionals and health organizations
- Child protective services and other social service providers
- Senior citizen's groups
- Interest clubs such as book clubs and garden groups
- Men's groups including sport's leagues
- Neighborhood organizations such as crime watches and block clubs
- Housing programs / coalitions
- Mutual support (self help) groups
- Local media (websites, radio stations, television stations, and newspapers)
- Law enforcement
- Political office (e.g., county boards, city councils, attorney general, governor)
- Individual and community-level resources and assets
- Funding allocation to prevent SV and/or IPV
- Individual and organizational prevention capacity

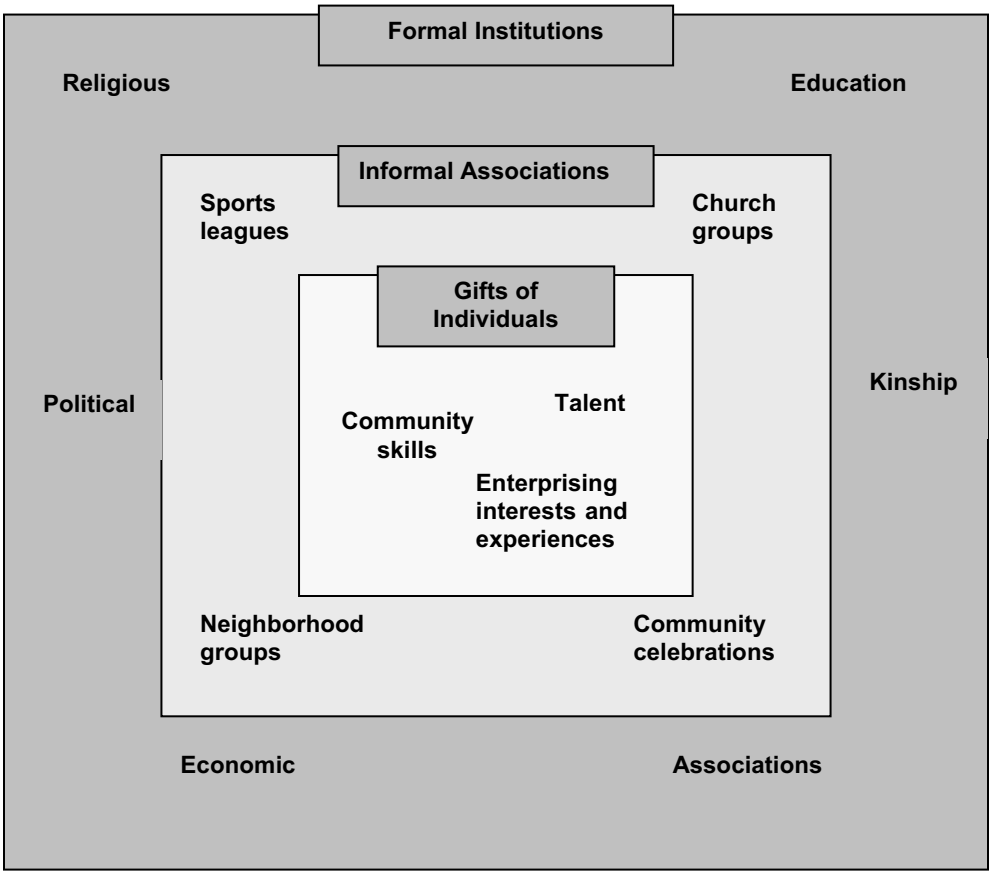
Once you have identified the organizations in your community that may be potential partners in the work to prevent IPV and/or SV, you can conduct a more detailed assessment of each organization. First, carefully consider your Needs and Resources Assessment Work Group's resources to conduct this assessment to ensure that this task does not become too overwhelming. You may want to prioritize which organizations to assess based on some criteria developed by the Needs and Resources Assessment Work Group. For example, the Work Group may want to first review any programmatic guides that provide an overview of what each agency does and which have already been developed by a local United Way or similar organization. Consider the activities in which the organizations are currently engaged. What is their current

level of capacity and motivation to do or integrate IPV and/or SV prevention within their current focus area? What is the current level of capacity and motivation to allow these organizations to integrate their current focus area into current IPV and/or SV prevention strategies? Are they involved in a partnership to prevent SV and/or IPV? Are there overlapping risk and protective factors between their issue (e.g., drug abuse prevention) and IPV and/or SV?

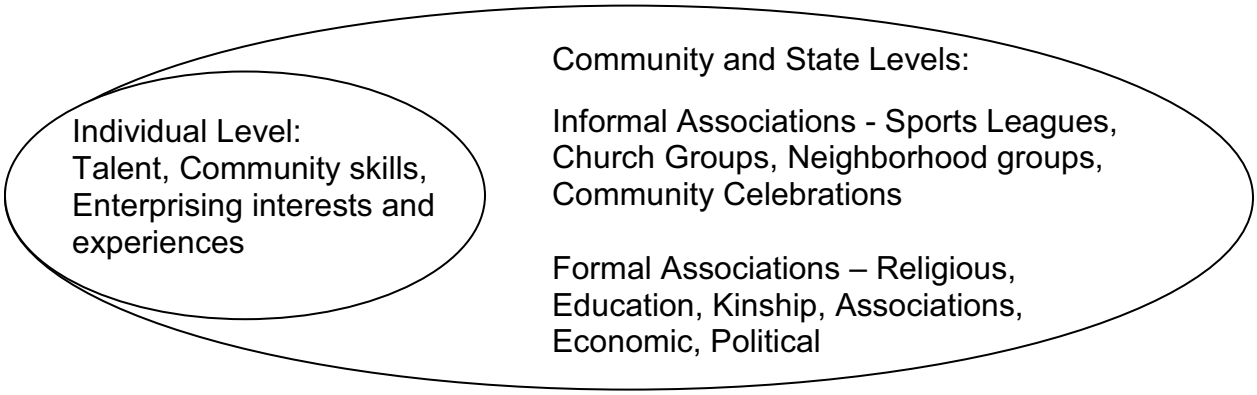
One tool that may be useful for surveying organizations and agencies Family Support America's *A Survey of Organizations and Agencies Serving Children, Youth, and Families* which is available in a manual titled: *Know Your Community: A Step-by-Step Guide to Community Needs and Resources Assessment* (Samuals, Ahsan, & Garcia, 2005).

Once you have identified the resources available in your community/state, it may be useful to map the resources in a format that can be easily seen and shared with others. Kretzmann and McKnight suggest placing community assets on the map in layers that include gifts of individuals in the center, informal associations as a middle layer, and formal institutions as the outer surrounding layer—similar to the way the social-ecological model is described (see the *Kretzman and McKnight Asset Mapping Tool* below). The *Kretzman and McKnight Asset Mapping Tool* was developed for identifying community level assets and may be less applicable to state level planning.

Kretzman and McKnight Asset Mapping Tool



The *Kretzman and McKnight Asset Mapping Tool* can also be displayed to reflect the **Social Ecological Model** presented in the *Introduction to the Primary Prevention of IPV and SV from a Public Health Perspective.*



Communities and states may also wish to map the resources geographically to examine the geographic distribution of resources. For instance, are more resources located in urban areas? Or are more resources located in affluent areas? Are resources easily accessible by a form of public transportation?

When your state or community profile is complete, it should be used as a reference point for the rest of your needs and resources assessment. Your community or state community profile may reveal special populations or conditions that you want to be sure to explore further as you move into the next phase of your needs and resources assessment, which is to understand IPV and/or SV in your community or state.

If you are working at the state level…

If you are developing a statewide primary prevention plan for IPV and/or SV, your state profile should include a description of the prevention efforts that are already happening in your state. Doing this will reveal the prevention resources that already exist in your state as well as areas where prevention capacity still needs to be developed. You may need to adjust your approach to this assessment based on the time and resources you have available to spend on it.

A good place to start learning about the prevention work that is taking place in your state is with the programs that are funded by organizations involved in your GTO Planning Team. For example, in the area of SV prevention, each state health department receives funding for a Rape Prevention and Education (RPE) cooperative agreement from the CDC. Funding from this cooperative agreement is distributed to state and local level grantees that carry out prevention work. Understanding how this funding is used can help provide an understanding of what prevention activities are in place. Some questions to ask could include:

- What prevention strategies are being used? Are these strategies primary prevention? What level of the social ecology do they address?
- What evaluation is taking place of the prevention strategies used?
- What is the current prevention and evaluation capacity of local level RPE grantees?

The CDC does not have a nationwide program which provides funding for IPV prevention. Some state domestic violence coalitions receive DELTA Program cooperative agreement funds that are distributed to local level grantees. In those states similar questions could be asked about the work of local level grantees.

In addition to the RPE and DELTA programs, there are likely to be other activities to prevent IPV and SV in your state. Members of your GTO Planning Team are one resource for identifying other prevention activities. They may be aware of SV or IPV prevention activities being carried out by local sexual assault programs, local domestic violence programs, local school districts, other state level coalitions (i.e. teen pregnancy prevention), your state department of education, the criminal justice system, or your state health department or coalition. They can also help you assess what resources these organizations devote to the prevention of IPV or SV.

Tools to assist with the process of assessing existing prevention efforts are currently being developed, and will be included as an appendix to Step 1 as soon as they are available.

Understanding Sexual Violence and Intimate Partner Violence in Your Community or State

In order to develop a comprehensive plan for the primary prevention of IPV and/or SV, your GTO Planning Team needs to understand SV and/or IPV in your own community or state. By systematically gathering national, state and local data from both existing and new data sources, your GTO Planning Team members will expand their understanding of SV and/or IPV based on *community knowledge* and challenge their pre-existing assumptions about these problems.

Trying to understand SV and/or IPV in your community or state can feel overwhelming. We suggest breaking it down into three questions to guide your work. Based on the answers to these questions, you will be able to identify your priority needs.

Question #1: What is the magnitude of IPV and/or SV among universal and selected populations?

Another way to ask this question is "how big is the problem and who does it affect most"? To answer this question, you should look for data that describe the number and percentage of people who have been victims of various forms of IPV or SV and the demographic characteristics of victims and perpetrators. First, you will look at data for your **universal population,** the general population of a community or state where differences in risk are not taken into consideration. Then you will refer back to your *community or state profile* to begin to assess how SV and/or IPV affect the various sub-groups within your community or state. Are there gender differences in perpetration and victimization rates? Are there differences among various racial and ethnic groups? Are there differences by age group? How does SV and/or IPV affect people with disabilities? It is important that this stage of your needs and resources assessment process builds upon your community or state profile. However, you may find that a sub-group has been left out of your community or state profile. If that is the case, information on that subgroup can be added now. By assessing differences in how SV and/or IPV affect various groups identified in your community or state profile, your NRWG will begin identifying populations who are at greater risk of perpetrating or experiencing IPV and/or SV in your community or state. Groups who are at greater risk of perpetrating or experiencing SV and/or IPV are referred to as **selected populations**. Identifying selected populations is an initial step toward promoting *social justice* in your community or state by ensuring that the needs of populations is clearly articulated and considered in later resource allocation decisions. Thus, *community knowledge* is enhanced by understanding these differences, while the NRWG and GTO Planning Team practices *accountability* to the broader state and community by being able to justify their decisions based on available data and resources.

Question #2: What can be changed or modified to reduce IPV and/or SV?

To answer this question, you will look for **risk factors** that appear to be contributing to the problems of IPV and/or SV in your state or community. You will also look for potential **protective factors** that may be reducing the likelihood that IPV and/or SV occurrs in your community or state. The NRWG will assess risk and protective factors for both universal and selected populations. You will need to balance the use of *evidence-based research* and *community knowledge* to determine which risk and protective factors are relevant in your community or state.

Question #3: How can the SV and/or IPV primary prevention system capacity be improved to strengthen our community's or state's work to prevent SV and/or IPV?

The **SV and/or IPV primary prevention system** is the network of organizations and individuals that supports and expands the work of the 4-Step public health approach to addressing IPV and /or SV. This network is referred to as a prevention system due the responsibility to prevent IPV and/or SV not belonging to any singular organization or group and due to the network having a dynamic nature that is influenced by internal and external issues. The SV and/or IPV primary prevention system as a whole is greater than the sum of its parts. The SV and/or IPV primary prevention system is composed of many organizations and individuals, the relationships among these organizations and individuals, the leadership within and these organizations and the community or state, and the processes that link these organizations.

Specific elements of an SV and/or IPV primary prevention system are:

1. Leadership (recognized authority, legitimacy, accountability or influence)
2. Strategic Planning
3. Community Focus
4. Human Resources
5. System Operations (organizations, strategies, programs, and processes)
6. Information (data collection, analysis, and management)
7. Results/Outcomes Documented

More information on these specific elements of an SV and/or IPV primary prevention system will be available at the end of January 2007.

If you find that it is difficult to find answers to the questions regarding the magnitude of SV and/or IPV and risk/protective factors in your community or state because of a lack of reliable data sources in your community or state, then your NRWG has identified key elements of the SV and/or IPV primary prevention system that need strengthening. Other elements of your prevention system may have been identified in your community profile (i.e., Individual and community-level resources and assets, funding allocation to prevent SV and/or IPV**,** Individual and organizational prevention capacity). Identifying and defining the prevention system capacity in each community or state promotes *improvement, capacity building, community knowledge,* and *accountability.*

Each of these three questions will be addressed individually throughout the remainder of this section. However, your search for answers to these questions will not necessarily be a linear process. Therefore, you probably will not finish answering each question before you start finding answers the next one. It is possible that any one data source may tell you something about all three questions.

The importance of critical thinking about data is a theme that will emerge repeatedly throughout the rest of this section on understanding IPV and/or SV in your community or state. Critical thinking about data requires an understanding of the flaws and limitations of data. The following pages summarize common limitations of data about IPV and SV. As you proceed through the rest of this section, each data source you use should be considered in light of these limitations, and in light of how that data compares to other data that are available to you. A figure summarizing a process for critical thinking about data is provided on p. 58 as a final note to this section.

Appendix D includes a *Process for Gathering and Interpreting Data for a Community or State Level Needs Assessment.* This assessment summarizes the steps suggested in this section and provides a brief example of how this process might take place within a state-level prevention planning team.

Understanding the Value and Limitations of Data About IPV and SV

No single source of data is perfect. Even with their limitations, however, data can provide valuable information and insight about problems and assets within a community or state when they are interpreted accurately. A number of key issues to consider when interpreting what data really mean are reviewed here with some suggestions about how to address each issue. As you work through the rest of the chapter, these issues will surface repeatedly with additional suggestions for how to interpret data based on these issues. Remember to apply these considerations to both existing data and new data collected by your Needs and Resources Assessment Work Group.

What is the focus or perspective represented in the data?
Different sources of data about IPV and SV tend to focus on different parts of the problem. For example, the National Crime Victimization Survey defines IPV and SV as crimes, while other surveys define these two issues as relationship or health problems. Prosecutors keep records on perpetrators. Health systems are focused on victims. Each of these perspectives only gives part of the picture. As a result, records on victimization may not indicate how many perpetrators participated in the assault of the victim, or whether more than one victim was violated by the same perpetrator. Likewise, data about perpetrators may not reveal the number of victims who were assaulted by a single perpetrator. Most data is victimization-focused and most perpetration data are limited to those who have been apprehended, charged, or convicted of a crime.

> What you can do to address this issue: Because no single source of data can provide an overall picture of the problem, it is important to look at several sources of data together, including sources about perpetration and victimization. As you add layers of information, you will develop a better understanding of IPV and SV in your community or state. The strengths of one data source can be used to offset the limitations of another data source.

How are IPV and SV crimes, offenses, or incidents defined in the data?
Different sources may base data collection on different definitions of an offense or an incident. For example, some data sources on sexual assault use a conventional definition of rape, which requires forcible penile-vaginal penetration of a female against her will (Bienen, 1981; Koss, 1993), whereas other sources may base statistics on an expanded definition of rape to include penetration with foreign objects, statutory rape (sexual intercourse with someone under the age of consent), sexual intercourse with victims unable to give consent due to the influence of alcohol or other drugs, or due to developmental delays or mental illness. With regard to IPV, different hospitals may define serious injuries that result from physical assault in different ways.

> What you can do to address this issue: Compare the definitions of and questions used to assess IPV and/or SV in each data source you use to determine whether differences in statistics are a reflection of different definitions or questions.

Understanding the Value and Limitations of Data About IPV and SV

Who is included, what groups are aggregated together, and who is left out of the data?
Traditional data sources such as state and national surveillance and **population-based surveys** generally fail to measure the impact of SV and IPV in the Lesbian, Gay, Bisexual, and Transgender population, among people with disabilities, older adults, youth, and immigrant/refugee populations.

> What you can do to address this issue: When looking at data, ask yourself, who is missing from the picture – especially who in your community or state is missing? For instance, in Montana it might be important to ensure that Native Americans are adequately represented, while in Alaska it might be important to ensure that Alaska Natives and Russian immigrants are represented, while in Florida it might be important to make sure Haitian immigrants are represented. To help assess who is missing, your Needs and Resources Assessment Work Group will want to review the community or state profile. What alternative data sources can be gathered to understand the problem among populations that are traditionally left out? Attempt to gather information about groups who are left out of traditional data sources by conducting your own surveys, conducting town meetings or focus groups with specific populations.

What is the impact of non-reported crimes and non-disclosure on the data?
Non-disclosure is the greatest threat to the valid interpretation of most data about SV and IPV. Most IPV incidents are not reported to the police; meanwhile, nearly all of the available data on perpetration are based on data from the criminal justice system, which does not include perpetrators who were never charged with a crime. Research based on phone surveys has shown that only 20% of IPV rapes and/or sexual assaults, 25% of physical assaults, and 50% of stalkings directed toward women are reported and even fewer IPV incidents against men are reported (Tjaden, & Thoennes, 2000b). In summary, available data from law enforcement, hospitals and service provider records are believed to greatly underestimate the true magnitude of the problems of SV and IPV.

> What you can do to address this issue: The actual rates of IPV and SV in your community can be estimated by applying the rates of unreported offenses revealed by research to the population of your community or state. See instructions on page 41.

How are the data collected?
Surveys and interviews collect information about IPV and/or SV that may otherwise go unreported. However, survey data can remain flawed due to non-disclosure, difficulty reaching certain participants, poor survey questions, or poorly trained interviewers. Telephone surveys only reach households with land-line telephones, therefore reducing representation of the general population. Other limitations of **surveys** might be the sample size of the study, how problems are measured, and whether the study is ongoing or just a one-time data collection. The limitations of the data collection process are usually described in the executive summary.

> What you can do to address this issue: Carefully consider how survey data is collected before interpreting what the data mean. Are the results of the survey likely to be underrepresented or inflated based on the limitations of the survey?

Question #1: What is the Magnitude of IPV and/or SV among Universal and Selected Populations?

The **magnitude** of IPV and/or SV is a way of describing the size of the problem or the extent of the problem. First, you want to know how big the problem is among the general population within your state or community—your **universal population**.

You also want to know if certain groups within your universal population experience or perpetrate SV and/or IPV to a greater extent than other groups. In all likelihood, these groups were identified in your community profile. You might find differences in the magnitude of IPV and/or SV between age groups, gender groups, socioeconomic groups, racial groups, or geographic groups/neighborhoods and/or any combination of the above. Groups that experience a higher rate of IPV and/or SV victimization or perpetration within your geographic area of interest will be your identified **selected population(s).**

Identifying selected populations is a critical aspect of the public health model—by knowing who is most affected by a problem, we can be more effective and efficient in our efforts to prevent the problem. By using prevention efforts to decrease risk disparities across groups, we promote *social justice* within our communities and states.

It is important to recognize that not everyone working in the field of IPV and/or SV prevention is equally comfortable with identifying selected populations. One concern is that looking for differences in the rate of IPV and/or SV across groups could lead to victim blaming or reinforce prejudices towards certain groups. The fear is that if a group experiences a problem more than other groups, then some people might think that members of the higher risk group are in some way responsible for causing their own problem. In fact, differences in the rate at which different groups experience a problem generally stem from differences in exposure to community and societal risk factors that promote the problem and/or protective factors that protect against the problem. Therefore, by identifying selected populations, we create the opportunity address these risk and protective factors in a manor that promotes *social justice*.

Another common concern about identifying selected populations is that if we focus on a particular selected population that is at greater risk of IPV and/or SV, then people might assume that other groups are not at risk or are immune to the problem. In fact, a comprehensive prevention plan should address both universal and selected populations to be effective. This GTO manual promotes the development of a comprehensive community or state plan that defines the needs of the entire community or state, not just the needs of a particular group. By identifying the needs of the universal population, we recognize that no one is immune to the problem of IPV and/or SV, there are common risk factors that affect everyone, and that prevention efforts should be directed to everyone. Understanding the needs of universal populations allow communities and states to see similarities across groups. By addressing selected populations, we recognize that differences exist within our communities as some groups are at greater risk and deserve more concentrated efforts to help reduce disparities as compared to

the universal population. Comprehensive prevention plans should increase community knowledge by clearly acknowledging similarities and differences. Additionally, it is very important that any group identified as a selected population by you NRWG is adequately represented on your NRWG or GTO Planning Team to insure that biases and stereotypes, if they surface, are challenged, rather than perpetuated.

Your Needs and Resources Assessment Work Group and GTO Planning Team should have an open dialogue about these concerns and issues. No one can control how every person interprets or uses information, but open dialogue and education about the purpose of identifying selected populations can be a safeguard against misunderstandings and unintended consequences of identifying selected populations.

Terms Used to Describe the Magnitude of IPV and/or SV

The public health field uses estimates of prevalence rates, incidence rates, and occurrence to describe the magnitude of IPV and SV. A **prevalence rate** of IPV or SV refers to the proportion (or percentage) of persons perpetrating or experiencing IPV or SV within a specified population and/or geographic area during a specific period. To calculate a prevalence rate, the estimated number of people victimized (or the estimated number of people who perpetrated) within a specific region is divided by the total population within that same region. When prevalence is based on the proportion of persons who have perpetrated or experienced IPV and/or SV at any point in their lifetime, it is known as lifetime prevalence rate. When prevalence is based on the proportion of persons who have perpetrated or experienced IPV and /or SV during a given year, it is known as an annual prevalence rate (Tjaden & Thoennes, 2000a).

A limitation of lifetime prevalence rates is that they are not very sensitive to change over time. Regardless of how successful a primary prevention strategy may be, it could be many years before much change is seen in a lifetime prevalence rate. This is because even though fewer people may have been victimized in recent years, any person who has ever been victimized would still be included in a lifetime prevalence rate. Annual prevalence rates on the other hand are more likely to show the effects of primary prevention efforts because they only include the number of persons victimized in a given year. However, annual prevalence rates also have limitations, including underreporting. In regard to victimization from IPV or SV, this underreporting may be due to victims still feeling threatened by their perpetrator due to the relationship continuing.

Lifetime and annual prevalence rates only report how many people have been affected by IPV or SV. These rates do not reflect patterns of ongoing violence among repeat offenders or victims of multiple assaults. That is, these rates do not tell you how many times a person has assaulted or been assaulted. The number of assaults is referred to as **incidents** or **occurrences** of SV and/or IPV (see below). You should keep this limitation and other limitations of data about the magnitude of IPV and SV in mind as you work through the remainder of this chapter.

An **incidence rate**[5] of IPV or SV is the proportion people who experience first-time IPV and/or SV for the first-time or perpetrate IPV and/or SV for the first-time within a given time period, usually one year, and within a specified population. One challenge of measuring incidence rates is that it can be difficult to determine when first-time perpetration or victimization actually occurs. Most hospital records or police records will not tell you anything about whether a given crime or injury was a first-time event. Most standardized surveys do not assess for incidence, although with slight modification to their survey instrument, such an assessment could occur. One way to assess incidence is by self-report surveys that ask whether a particular experience was the first time the respondent perpetrated IPV or SV or experienced IPV or SV.

The **occurrence** of IPV or SV is the number of separate incidents of IPV or SV experienced or committed during a specific time period, usually one month or one year. Whereas incidence and prevalence rates are based on the proportion of persons in a given area affected by IPV and/or SV, occurrence is based on the number of IPV or SV related incidents that occurred in a given time period. The National Violence Against Women Survey reported that more than 200,000 women had experienced rape within an intimate partnership within the past year and that the average number of times these women were raped was 1.6. Thus, in the year prior to the survey, the total estimated number of rapes that occurred within intimate partnerships was more than 320,000.

All measures of magnitude—prevalence rates, incidence rates, and occurrence—can be estimated for different geographic areas including national, state, and/or local populations and for various population groups such as gender, racial, socioeconomic and/or age groups. They can also be estimated for different types of crime or events such as attempted and/or completed rape, physical assault of a partner, psychological abuse, etc.

Because of the nature of IPV and SV and the high rates of non-reported SV and IPV, no single data source will reveal the true magnitude of IPV and/or SV among universal and selected populations in your community or state. Therefore, a recommended practice is to *estimate* the magnitude of SV and IPV among universal and selected populations based on multiple sources of information.

Using Existing Data Sources to Estimate the Magnitude of IPV and/or SV

Before you spend time and resources collecting new data, you should find, gather, and examine data about magnitude of IPV and/or SV that already exist. Only after you have collected and analyzed existing data will you be able to identify the information gaps

[5] The most common definition of incidence refers to the proportion of *new cases* of a disease or health problem over a given time period. When referring to a public health problem such as HIV infection, a new case refers to a person who has just been diagnosed with having an HIV infection. However, due to the historical context in which IPV and SV have been addressed, applying the term *new cases* to IPV and SV has often been construed as referring to the number of *new cases or occurrences* reported to law enforcement. Thus, the definition of incidence of IPV and SV does not use the term new cases, but instead focuses on the proportion of people reporting first-time perpetration and first-time victimization.

that might be addressed by collecting new data. Information about how to collect new data is provided in the next section.

It is important that you not draw final conclusions about the magnitude of IPV and/or SV from existing data sources alone. Rather, you will only develop a preliminary estimate of the magnitude of IPV and/or SV and identify potential selected populations from existing data sources. Only after you collect new data to fill in the gaps left by existing data sources will you be able to make community or state informed estimates about the magnitude of IPV and/or SV.

There are a variety of sources of existing data about IPV and SV. The following pages provide a detailed summary of sources of existing data about IPV and/or SV and practical tips for accessing such information.

Sources of Existing Data about Sexual Violence and Intimate Partner Violence

Reports and Data from Standardized Surveys

Standardized survey data are systematically collected by administering a standard set of questions (i.e. questionnaire) to a representative **sample** of individuals. Surveys can be administered at national, state and local levels. Data about IPV and/or SV collected by standardized surveys are thought to be more accurate than police or a service provider data as some respondents reveal experiences that were never reported to the police or service providers. Standardized survey data is considered to be more accurate due to its methodology of administering the questionnaire to a sample of people who are representative of the population on particular characteristics such as income, race/ethnicity, or gender. However, even standardized survey data are limited by unreported victimization.

At the national level, the **National Violence Against Women Survey (NVAWS)** was conducted in 1995-1996 by telephone interviews with a nationally representative sample of 8,000 women and 8,000 men. The study was sponsored jointly by the National Institute of Justice and the CDC. The survey asked participants about their experiences as victims of sexual violence and intimate partner violence. Several government reports have been published from this data that provide national estimates of the prevalence of IPV and/or SV among women and men by age and racial/ethnic groups. Many research reports have also been published by scientists in peer reviewed journals (see page 39 on how to access). The results of this survey provide the best national estimate of non-reported crimes to date. However, the data are now 10 years old and need to be updated. This survey also lacks detailed information about the characteristics of perpetrators.

At the state level, the **Behavioral Risk Factor Surveillance Survey (BRFSS)** is an on-going telephone health survey system that has tracked health conditions and risk behaviors among adults in the U.S. annually since 1984. The survey is administered by the 50 state health departments with support from the CDC and provides state-specific information about a wide range of health issues. In 2005, optional survey modules on intimate partner violence and sexual violence were developed by the CDC based on IPV and SV definitions. In 2005, 20 states or territories used the sexual violence module and 12 states or territories used the

Sources of Existing Data about Sexual Violence and Intimate Partner Violence

intimate partner violence module. BRFSS data can now be viewed locally in over 170 metropolitan areas. If your state does not already collect the optional modules on IPV and/or SV, you may want to consider identifying that as a need for improving your state's prevention system capacity. Your community or state may consider administering the surveys themselves.

The **Youth Risk Behavior Surveillance System (YRBSS)** was developed in 1990 by the CDC to track health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States. These behaviors, often established during childhood and early adolescence, include tobacco use; unhealthy dietary behaviors; inadequate physical activity; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; and behaviors that contribute to unintentional injuries and violence. Some of these behaviors—such as substance use, sexual behaviors, and behaviors that contribute to violence—are of interest to those working to prevent SV and/or IPV. The YRBSS includes national, state, and local school-based surveys of representative samples of 9th through 12th grade students conducted every two years. The survey is only collected from youth who attend school so it is not a representative sample of all youth. The amount of under-reporting or over-reporting behaviors on the survey cannot be determined, although survey questions demonstrate good test-retest reliability. You can find out if YRBSS data are available in your state or community by visiting the website listed on p.39.

The **National Crime Victimization Survey (NCVS)** is an annual survey about criminal victimization in the U.S. Approximately 150,000 interviews of persons age 12 or older are conducted each year, drawn from a nationally representative sample. The survey collects information about violent and non-violent crime—violent crimes measured by the survey include rape/sexual assault, robbery, aggravated assault, and simple assault. The survey provides information about victims (age, sex, race, ethnicity, marital status, income, and educational level), offenders (sex, race, approximate age, and victim-offender relationship), and the crimes (time and place of occurrence, use of weapons, nature of injury, and economic consequences). Questions also cover the experiences of victims with the criminal justice system, self-protective measures used by victims, and possible substance abuse by offenders. The survey asks participants about crimes, whether or not they were reported to the police. A limitation of the survey is that it does not distinguish between intimate and non-intimate perpetrators or victims. When interpreting the data, it is important to consider how definitions and terms used in the survey affect reporting rates.

Research Articles, Briefs, and Reports

Researchers from various fields such as public health, criminal justice, social work, psychology, and sociology have conducted research regarding IPV and SV and published their findings in peer-reviewed articles, briefs and reports. Below are just a few examples of the kinds of reports that are available:

- Researchers published a peer-reviewed article in 1998 that reported risk factors for intimate partner homicide-suicide in North Carolina (Morton, Runyan, & Moracco, 1998).

- In 2004 National Institute of Justice published a Research in Brief titled *Violence Against*

Sources of Existing Data about Sexual Violence and Intimate Partner Violence

Women: Identifying Risk Factors that identified some risk factors for perpetration and victimization for sexual violence and intimate partner violence (NIJ, 2004; http://www.ncjrs.gov/pdffiles1/nij/197019.pdf).

- The National Criminal Justice Reference Service (NCJRS) (http://www.ncjrs.gov/) periodically publishes research reports on both IPV and SV. In 2005 the NCJRS published a report titled *Estimate of the incidence of drug-facilitated sexual assault in the U.S., Final Report* (Negrusz, Juhascik,, & Gaensslen, 2005; http://www.ncjrs.gov/pdffiles1/nij/grants/212000.pdf) that reported estimates of drug-facilitated rape and the social aspects linked to this type of sexual violence.

You can search for additional reports that may be based on data from your state on the internet. Public libraries can also be of enormous assistance in accessing research articles, briefs and reports that assist your Needs and Resources Assessment Work Group in completing the needs and resources assessment.

Law Enforcement Records

Law enforcement records can provide information about crimes reported to the police and arrests made in relation to those crimes. Reporting rates such as those reflected in data from the National Violence Against Women Survey tend to be higher than arrest rates. Police records generally will include the number of reports and number of arrests made for each type of crime (e.g., aggravated assault; rape). Ideally, records will also include the geographic location of reported crimes; the age, race, and gender of the victims of the crimes; as well as the age, race, and gender of perpetrators arrested for crimes in each category.

Some of the benefits of using law enforcement reports as a source of data are:

1. An examination of law enforcement data allows all members of the NRWG or GTO Planning Team to become educated on the limitations of these data and how these data compare to data from representative samples.
2. These data require minimal cost to obtain.
3. These data allow members of the NRWG and GTO Planning Team to develop a better understanding of how law enforcement resources are being used to address IPV and/or SV as part of the prevention system capacity assessment.

To access law enforcement records, you will want to develop a working relationship with a point of contact within the law enforcement agency who manages information available to the public. If you have not already, you may want to consider including someone from the law enforcement community on your GTO Planning Team. This engagement would not only foster better access to law enforcement data, but would also add a valuable perspective to your overall planning team.

Some states and local areas have created clearinghouses which provide information involving particular IPV and/or SV incidents involving the same parties in multiple jurisdictions. These clearinghouses are created to flag cases involving three or more occurrences to track appropriateness of law enforcement and referral services provided.

Sources of Existing Data about Sexual Violence and Intimate Partner Violence

When considering law enforcement data, remember that IPV and/or SV incidents are vastly underreported to the police. Law enforcement generally tracks incidents, not victims and/or perpetrators (with the exception of special offense-related clearinghouses). Law enforcement agency reports include only those incidents that rise to the level of a criminal act.

An easy way to access law enforcement data is through the **Uniform Crime Reports (UCR)** compiled by the Federal Bureau of Investigation (FBI). UCR data are compiled from monthly law enforcement reports or individual crime incident records sent to the FBI from nearly 17,000 law enforcement agencies across the U.S. The UCR Program provides crime counts for the nation as a whole, as well as for regions, states, counties, cities, and towns. Crimes are classified and reported according to a standard set of uniform crime offense definitions.

UCR data are published annually in a detailed report, *Crime in the United States*. In addition to crime counts and trends pertaining to homicide, forcible rape, and aggravated assault, this report includes data on crimes cleared, persons arrested (age, sex, and race), law enforcement personnel (including the number of sworn officers killed or assaulted), and the characteristics of homicides (including age, sex, and race of victims and offenders, victim-offender relationships, weapons used, and circumstances surrounding the homicides). Other special reports are also available from the UCR Program. The UCR Program is currently being converted to the more comprehensive and detailed National Incident-Based Reporting System (NIBRS). NIBRS will provide detailed information about each criminal incident in 22 broad categories of offenses.

Unlike data collected from surveys (such as the National Crime Victimization Survey), UCR data only include crimes reported to the police. Not all victims of IPV and/or SV report their victimizations to police. Therefore, UCR data should be considered an underestimate of the actual number of IPV and/or SV incidents that occur in a given region.

Hospital Records

Hospital records can provide information about the number of individuals who seek and receive medical treatment for injuries sustained as a result of SV and/or IPV. Hospitals may also keep records on the type of assaults that occurred, the injuries sustained, medical services provided, and information about the age, race, and gender of victims. Hospital records may include data that are not included in police records because not all victims who seek medical services report IPV and/or SV related crimes to the police. We can be fairly certain that not all victims of IPV and/or SV seek medical treatment either. Therefore hospital records should be considered an underestimate of the actual number of IPV and/or SV related injuries that occur in a given region.

Some of the benefits of using law enforcement reports as a source of data are:

1. An examination of health care data allows all members of the NRWG or GTO Planning Team to become educated on the limitations of these data and how these data compare to data from representative samples.
2. These data require minimal cost to obtain.
3. These data allow members of the NRWG and GTO Planning Team to develop a better understanding of how health care resources are being used to address IPV and/or SV as part of the prevention system capacity assessment.

Sources of Existing Data about Sexual Violence and Intimate Partner Violence

To obtain information from hospitals, develop a working relationship with a point of contact within each hospital located within your geographic area. When available, contact the hospital's Forensic Nurse Examiner (FNE) who is designated to work with crime victims, including victims of IPV and/or SV. You should also ask if the hospital emergency department has a Sexual Assault Nurse Examiner (S.A.N.E.) Program. S.A.N.E. Programs may have additional information about whether cases were prosecuted and their outcome as S.A.N.E. nurses often provide expert witness testimony in the criminal justice system. If you have not already, consider including a hospital administrator or medical records department staff on your GTO Planning Team to foster access to hospital data, and to add a valuable perspective to your overall planning team.

Of course, hospitals will not disclose any identifying information about the patients they serve; however, you may still need special permission to obtain non-identifying information. Do not be surprised if it takes some time to work through the proper channels to obtain the information you are seeking. If information is not available, you may want to consider identifying this as a need for your prevention system capacity for improvement in the future.

The **National Electronic Injury Surveillance System – All Injury Program (NEISS – AIP)** collects data on all types and external causes of nonfatal injuries and poisonings treated in U.S. hospital emergency departments. The system is a collaborative effort between CDC's National Center for Injury Prevention and Control and the Consumer Products Safety Commission. Data are collected from a nationally representative sample of 100 hospital emergency departments. Data from NEISS-AIP can be used to monitor trends over time in nonfatal injuries. All injuries in the system are classified for the intent of injury including: unintentional, assault, self harm, or legal intervention. The mechanism of injury is also classified (i.e., fall, struck by/against, motor-vehicle-occupant--related incident, cut/pierce, and fire/burn).

The information from the NEISS-AIP system that is most relevant to IPV and/or SV prevention planning is the data on injury caused by assault which includes suspected and confirmed injuries from interpersonal violent events (e.g., injuries to victims, innocent bystanders, police, and perpetrators). To access the information from the system, simply go to the system's website (provided on p. 39) where you can enter a query for the information of interest to you and your planning team.

Service Provider Records

Aside from hospitals and the criminal justice system, other service providers like local domestic violence programs, rape crisis centers, batterer intervention programs, sex offender treatment programs, and hotlines can offer additional information about the magnitude of IPV and/or SV and those at greatest risk for SV and/or IPV. In addition, some state domestic violence coalitions or agencies maintain statewide victim service data.

Just like any other data source, there are limitations to data available from services providers. Not all victims seek survivor services, so data from these sources are not based on a representative sample. Also, a survivor who receives victim services could have experienced

Sources of Existing Data about Sexual Violence and Intimate Partner Violence

more than one assault by one or more perpetrators. Multiple survivors could have been assaulted by the same perpetrator which would probably not be revealed by data provided by service providers. Survivors seek services at various stages of recovery and the time frame for seeking services varies greatly among survivors. Some groups may be more or less likely to seek services after they have been victimized.

Some of the benefits of using law enforcement reports as a source of data are:

1. An examination of service provider data allows all members of the NRWG or GTO Planning Team to become educated on the limitations of these data and how these data compare to data from representative samples.
2. These data require minimal cost to obtain.
3. These data allow members of the NRWG and GTO Planning Team to develop a better understanding of how service provider resources are being used to address IPV and/or SV as part of the prevention system capacity assessment.

To obtain data from services providers, develop a working relationship with representatives of service provider agencies. Consider including someone from these agencies on your GTO Planning Team to foster better access to data and to add another valuable perspective to your planning team. When requesting information, let them know the purpose of your request and how the information will be used. You should not request or expect any data that reveals the identity of victims; rather, you should request information that indicates the number of victims served and any demographic information about those victims (e.g., the percent of victims who belonged to each gender, age, and racial category) and not any identifying information.

Summary of Existing Data Sources about IPV and/or SV That are Ready for Use

Source	Reports and/or Data Available from this Source	Website	National Level Data	State Level Data	Local Level Data
National Violence Against Women Survey *National Institute of Justice and Centers for Disease Control and Prevention*	*Extent, Nature, and Consequences of Rape Victimization* (report published January 2006)	www.ncjrs.gov/pdffiles1/nij/210346.pdf	✓		
	Extent, Nature and Consequences of Intimate Partner Violence (report published July 2000)	www.ncjrs.gov/pdffiles1/nij/181867.pdf	✓		
Behavioral Risk Factor Surveillance Survey *Centers for Disease Control and Prevention*	Prevalence of IPV in 12 states and territories (data collection began 2005)	www.cdc.gov/brfss/		✓ [6]	✓ [7]
	Prevalence of SV in 20 states and territories (data collection began 2005)	www.cdc.gov/brfss/		✓ [8]	✓
Youth Risk Behavior Surveillance System *Centers for Disease Control and Prevention*	Prevalence of health risk behaviors such as substance use, sexual behavior, and behaviors that contribute to violence among youth attending schools	www.cdc.gov/HealthyYouth/yrbs	✓	✓ [9]	✓
National Crime Victimization Survey *Bureau of Justice Statistics*	*Criminal Victimization in the United States* (report published annually)	www.ojp.usdoj.gov/bjs/welcome.html	✓		
Uniform Crime Reports *Federal Bureau of Investigation*	*Crime in the United States* (report published annually)	www.fbi.gov/ucr/ucr.htm	✓	✓	✓
National Electronic Injury Surveillance System – All Injury Program *Consumer Product Safety Commission and the CDC*	Types of non-fatal injuries caused by assault and characteristics of victims	www.cpsc.gov/library/neiss.html	✓		

[6] AZ, HI, IA, MO, NV, OH, OK, PR, RI, VT, VI, and VA
[7] Check website for availability in your area
[8] AZ, CO, CT, DE, FL, HI, ID, MS, MO, NV, OH, OK, PR, RI, SC, TN, VT, VI, VA, and WI
[9] Varies by state and year

Now you are ready to begin estimating the magnitude of IPV and/or SV in your community or state. The illustration on the next page represents a starting point for estimating the magnitude of IPV and/or SV within a universal population. You will notice the illustration draws from information collected from a community profile as well as existing data sources about sexual violence. A similar estimate in your state or community would provide a reference point for you to work from but may not represent the final estimate of magnitude that your work group settles on for your community or state. You should continue exploring as many other sources of data you can find about the problems of IPV and/or SV in your community or state. Each source of data is another piece of the puzzle. Talk about what each data source tells you and does not tell you. Continue this process until a picture about the problem emerges that makes sense based on all the information you have gathered.

How to Estimate Magnitude of IPV and/or SV at State or Local Levels Based on National Existing Data Sources: Case Illustration of Fulton County, Georgia

Existing Data Sources and Findings

National Violence Against Women Survey (NVAWS) (collected 1995-1996)

- 8.7 per 1000 women were raped in the preceding 12 month period.
- 1 in 5 women who were raped, reported their rape to the police.

U.S. Census data for Fulton County, Georgia (2004) (taken from community profile)

- Approximately 400,000 women live in Fulton County, Georgia.

FBI Uniform Crime Reports for Fulton County (2000)

- 413 rapes were reported to police in Fulton County in 2000.

Estimates Based on National Survey Data

First, estimate the number of rapes per year in Fulton County by applying the rate of 8.7 per 1,000 women found by the NVAWS study to the population of women in Fulton County as follows:

$$\frac{8.7}{1000} = \frac{?}{400{,}000} \qquad ? = 3{,}480 \text{ women}$$

Assuming that 8.7 women per 1000 women were also raped in one year in Fulton County as was found in a national sample, and there are 400,000 women living in Fulton County, then approximately 3,480 women would have been raped in Fulton County per year. There is no proof that number is correct; it is just an estimate based on national survey research findings and the population of women in Fulton County. Other similar calculations could be made based on other research findings about rates of other forms of sexual assault and/or intimate partner violence.

Second, calculate the reporting rate in Fulton County by dividing the number of reported rapes in a given year by the number of estimated rapes per year:

$$\frac{\text{413 reported rapes in Fulton Co. in 2000}}{\text{3,480 women raped in one year (estimate)}} = \frac{1}{8.4}$$

This calculation suggests that only 1 in 8.4 women report their rape in Fulton County per year as compared to 1 in 5 based on national survey based research. This raises new questions about why it appears that fewer women report rape to the police in Fulton County as compared to national statistics. Perhaps the number reflects a more conservative definition of rape held by the Fulton County criminal justice system. It could also suggest that there are actually fewer rapes in Fulton County as compared to the national population. The correct interpretation of the existing data will require further exploration by collecting additional data.

Using Existing Data Sources to Identify Preliminary Selected Populations

Once you estimate the magnitude of SV and/or IPV within your universal population you can begin to identify preliminary selected population(s), or the groups that appear to be at a heightened risk of experiencing and/or perpetrating IPV and/or SV in your community or state. The term 'preliminary selected populations' is used rather than the term 'selected populations' to indicate that a community or state should not rely solely on existing data sources when identifying groups at heightened risk for perpetrating or experiencing IPV and/or SV. Identifying preliminary selected populations allows you to get closer to prioritizing resource allocation in such a manner as to promote *social justice*. The key to identifying preliminary selected populations is to learn as much as you can about the characteristics of people who perpetrate or experienced IPV and/or SV within your community or state from existing data sources. It is also essential to present that data in such a manner as to promote an appreciative understanding of the similarities and differences among groups and among available resources for various groups. Hopefully, you will have representatives from various groups as members of your Needs and Resources Assessment Work Group or your GTO Planning Team. It is vital that various groups are represented in a substantive, rather than a tokenized, manner when the preliminary discussions of identifying selected populations occur.

The first step is use your community profile as a guide for deciding for which populations within your community or state you would like to have specific data regarding IPV and/or SV. If your community or state has a large Native American population, then the collection of data on the magnitude of SV and/or IPV within this population is warranted. If your community or state has a large population of immigrants from Romania, then the collection of data on the magnitude of SV and/IPV within this population is warranted. However, just because a group composes a large percentage of the population does not mean that groups that compose smaller percentages of the population should be ignored. When looking for data sources to help you understand the magnitude of IPV and/or SV among groups within your community or state as identified in your community or state profile, look for existing data sources that contains information about:

- age
- racial/ethnic identity
- socioeconomic status
- geographic location (e.g., zip code)
- sex
- people with disabilities
- sexual orientation
- acculturation status

When comparing magnitude of IPV and/or SV across demographic groups, it is very important to use percentage rates and not numbers. Numbers are not a useful comparison because the size of each group is probably different. In order to know whether a group is at greater risk than another group, you need to know the percentage

of people in that group who have perpetrated or been victimized (please see pp.32 for a discussion of prevalence rates and incidence rates).

Data from standardized surveys and research studies can be used as starting points for identifying what groups may be at higher risk for perpetrating or experiencing IPV and/or SV in your community or state. We refer to surveys and research studies as starting points as the groups examined in these studies may or may not share all the same characteristics with similar groups in your community or state and the community and societal level risk factors experienced by groups in a survey or research may not be the same as similar groups in your community or state. For instance, the National Violence Against Women Survey indicated that Native American women experience more IPV and SV than white women. However, this survey combined all Native American women into one number regardless of differences in tribal affiliation, geographic location, or community and societal risk factors associated with IPV and/or SV.

After you have looked at data from existing sources and research on IPV and/or SV, you can identify some preliminary selected populations who may be at greater risk of perpetrating or experiencing SV and/or IPV. Rarely will a community or state have just one selected population. You may have multiple preliminary selected populations upon which to focus. You may also realize that for some populations, you have very little data from existing data sources. The next step for identifying selected populations is to collect new information about SV and/or IPV among these preliminary selected populations. The following section provides information about how to collect new information about the magnitude of IPV and/or SV.

Summary of Critical Questions to Ask About Existing Data Sources

It is important to think critically about every existing data source you examine. A list of questions to help you think critically about both national and state/local level data sources to understand the magnitude of IPV and/or SV among universal and selected populations is provided below.

Questions about National Data Sources

- What does this data source tell us about the magnitude of perpetration and victimization among universal and selected populations at the national level? What does it not tell us, and what assumptions might be made based on this data?
- Recognizing how our state or community is similar to the rest of nation, what can we infer about our state or community based on this national data source?
- Recognizing what is unique about our state or community, what from this data source may not apply to our state or community?
- What definitions were used for the acts of violence measured? How was this data collected? What questions were used if it was a survey? How was prevalence estimated?
- Are any demographic groups or populations missing in the data?

Questions about State and Local Data Sources

- What does this data source tell us about the magnitude of perpetration and victimization among universal and selected populations at the state and/or local level? What does it not tell us, and what assumptions might be made based on this data?
- What definition was used for type of crime or assault that was measured? How was this data gathered? How was prevalence estimated?
- What does this data source tell us about differences across regions or counties within our state (if applicable)? What are possible explanations for the differences between regions or counties? (e.g. lack of data collection in some areas, problems with data entry, etc.)
- How are prevalence rates distributed across age groups? Do certain age groups show a higher rate of SV or IPV perpetration and victimization than others?
- How are specific populations represented in the data? For example, persons with disabilities, LGBT populations, native populations—is there evidence that these groups are disproportionately affected by IPV and/or SV?
- Where did acts of violence occur within our state or community? Were they clustered in certain areas of the community or state? Are prevalence rates higher in certain regions or areas (urban vs. rural), zip codes, school districts, or neighborhoods? Are there distinct socioeconomic features of areas that reveal higher rates of IPV and/or SV?
- How does this data on IPV and/or SV compare with data from our state or community profile? What are possible explanations for discrepancies between our state or community profile and state or local data on IPV and/or SV?
- Are any demographic groups or populations missing in the data?

Collecting New Data about Magnitude of IPV and/or SV Within Universal and Selected Populations

By now you should have a preliminary estimate of the magnitude of SV and/or IPV within your universal population as well as preliminary ideas about who your selected population(s) might be based on existing data and your community profile. However, you may still have some unanswered questions or gaps in the data that are preventing you from forming final conclusions about the magnitude of IPV and/or SV in your universal and selected populations.

Collecting new data can be helpful in learning more about specific populations that are underrepresented in your existing data. In addition, new data can help you understand what your existing data means. The following case illustration describes how one state collected information to understand the meaning behind an existing source of data.

Case Illustration: Collecting New Data to Better Understand Existing Criminal Justice Data

A criminal justice agency in New York asked the New York State Coalition Against Domestic Violence to work with a particular county within the state as part of a rural project initiative. This particular county reported the highest rate of intimate partner violence per capita in the state. After conducting a safety and accountability audit of the paperwork, the state coalition concluded that the high rate of IPV in the county was more reflective of police practices that were more likely to lead to arrest due to state of the art investigation techniques used and a pro-arrest policy within that police department than they were of a higher rate of IPV in that county. The state coalition also concluded that other counties in the state were likely to be underreporting their rates of IPV due to police practices that were less likely to lead to arrest. This example illustrates why one source of data about magnitude is not enough to determine what the real needs are in your state or community. In this example, an additional source of information (i.e., the safety and accountability audit) was used to develop a more accurate and meaningful interpretation of the magnitude of IPV in one county.

There are a variety of ways to collect new data. The following pages provide a summary of the most common methods for collecting new data. Each of the methods described can be tailored to fit the amount of time and resources your Needs and Resources Assessment Work Group has available for your assessment.

Ways to Collect New Data about Sexual Violence and Intimate Partner Violence

Surveys

Earlier we discussed data from some surveys that are already available to you such as the National Violence Against Women Survey. However, you can also use surveys to collect new data that is unique to your state or community. For instance, the data from the National Violence Against Women Survey is not available at state and local levels. To fill this gap, your Needs and Resources Assessment Work Group could use the same questions used in the National Violence Against Women Survey to assess IPV and/or SV within your state or community. Using the same questions allows you to compare your data to the data at the national level.

Surveys can provide useful information about IPV and/or SV including information about magnitude and risk and protective factors associated with SV and/or IPV (these topics will be discussed in more detail later in this chapter). Surveys usually assess knowledge, attitudes, experiences, and behaviors at the individual and/or relationship levels of the social ecology. Often, it is not practical to survey every person in a community. Ideally, surveys are usually administered to a representative sample of individuals. However, representative samples are often not feasible. In these cases, a convenience sample may be used. A convenience sample is one that is obtained fairly easily such as adolescents attending a high school football game or men entering a sporting goods store. Appendix C includes a list of surveys that may be used to collect data about IPV and/or SV. You can also use questions from national and state level surveys. You can usually find the questions that are used by an existing survey on the survey's website.

Key Informant Interviews

Key informant interviews are conducted systematically with leaders and/or community representatives such as public officials, providers of survivor services, abuser/offender treatment specialists, youth counselors, health care providers, administrators or staff members of welfare organizations, police chiefs, and/or local faith leaders. Key informants know the community and are likely to have valuable perspectives on what needs and resources exist in a community with regard to IPV or SV. However, some key informants can be somewhat removed from the actual experience of addressing IPV or SV so they should not be your only source of additional information. Additionally, key informants may have their own agenda that is influenced by their agency's mission and history and the history of addressing IPV or SV within that state or community. Thus, turf issues, funding streams, and other issues may influence the perspectives provided by key informants.

Ways to Collect New Data about Sexual Violence and Intimate Partner Violence

Community Meetings/Forums
With this approach, various individuals are invited to a series of meetings and are asked about their understanding of the needs and resources in the community or state with regard to SV and IPV. These meetings are intended to obtain information from the general public. A facilitator should help keep the focus of the meetings/forums on primary prevention rather than intervention.

Focus Groups
Focus groups are facilitated discussions with a small group of individuals (typically between 6-12 people) about a particular topic. A facilitator typically asks a series of open-ended questions to focus the discussion and to gather specific types of information. Focus groups can include a diverse group of individuals or they can include a group of individuals who share something in common such as a group of parents, teachers, youth, a particular ethnic group, or law enforcement. They are particularly useful for exploring attitudes, feelings, beliefs and behaviors of a group. Focus groups can be used to identify untapped resources within a community or state or to identify risk factors for perpetrating or experiencing SV and/or IPV within a community or state. A tool on conducting Focus Groups for IPV and SV prevention is included in Appendix B.

Environmental Scans
An environmental scan is a survey of your surroundings. The purpose of an environmental scan for SV and IPV prevention is to examine community and societal level risk and protective factors associated with IPV and SV that are present in your community or state. Environmental scans may include several different components such as media messages in your community; local, organizational, and/or state policies that impact SV and IPV; and/or environmental conditions that impact IPV and SV.

Media and Advertising Assessment
A media and advertising assessment can be used as a component of an environmental scan. A media and advertising assessment for SV and/or IPV prevention examines messages that are portrayed by the media that promote or protect against SV or IPV. All forms of media should be included such as newspapers, magazines, local television ads, billboards and signage, radio, etc. Specifically, you want to look for indicators of community level risk factors of SV or IPV that are portrayed through the media. You can also use it to look for community level protective factors.

Ethical Considerations When Collecting New Data

Whenever you collect new data from individuals, it is very important to consider the ethical implications of gathering that information. IPV and SV are sensitive and painful topics. Asking members of your community to disclose personal information about experiences related to IPV and/or SV calls for sensitivity and ethical responsibility.

Most research studies are reviewed by an Institutional Review Board (IRB) to prevent harm to those who choose to participate in research. Data collection for strategic planning and evaluation generally do not require IRB approval. However, most of the issues that an IRB review would look for should also be considered when doing planning and evaluation. When collecting information from other people, you should carefully consider the following:

Protect Privacy

How will you protect the privacy and confidentiality of individuals who choose to participate in an interview, focus group, or survey for the purpose of your needs and resources assessment?

Informed Consent

Provide participants with a written statement that provides participants with information regarding the topics to be addressed, confidentiality of the data, procedures, risk involved, and a place for their signature.

Be Respectful / Do No Harm

Will the questions that you ask cause participants any unnecessary stress or discomfort? Is so, you may want to consider whether you can gain the same information from another source or be sure to provide appropriate referrals (see next question).

Provide Appropriate Referrals

Are you prepared to provide participants with referrals to service providers who support survivors of IPV and/or SV or treat perpetrators of SV and/or IPV when appropriate?

You find a complete list of Guiding Principles for Evaluators at <www.eval.org/Publications/aea06.GPBrochure.pdf>.

Tip: Look Ahead Before You Collect New Data

If you decide to collect new data about the magnitude of IPV and/or SV within universal and selected populations, be sure to look ahead and consider information you might also want to collect about risk and protective factors before you start collecting new data. You can use the same data collection process to gather information about any part of your needs and resources assessment. For example, when interviewing community leaders you might ask them questions about the magnitude of SV and/or IPV, risk and protective factors related to the problem, and community assets. The same is true when conducting focus groups or surveys. By thinking about all the information you might need from each potential data source in advance, you can gather as much information as possible with each method of data collection, saving time and money in the process.

Question #2: What Can be Changed or Modified to Reduce IPV and/or SV?

In order to prevent the first time perpetration and first time victimization of IPV and SV, it is necessary to reduce **risk factors** that are associated with heightened risk of perpetration and victimization and to increase **protective factors** that are associated with lowered risk of perpetration and victimization. To do this, you need to know what risk factors and protective factors are relevant to the IPV and/or SV among both universal and selected populations within your community or state.

Research evidence on risk and protective factors for IPV and SV is in the very early stages of development. So far, more is known about risk factors for victimization than we do about risk factors for perpetration. Additionally, more is known about risk factors than protective factors for both perpetration and victimization. Finally, more is known about individual level risk factors than we do about community or societal factors. Although the **social-ecological perspective** regarding IPV and SV asserts that these two forms of violence result from the interplay of individual, social, and socio-cultural factors, we do not yet know which factors are most important. Additionally, we do not know which factors combine most frequently to lead to an occurrence of IPV and/or SV.

Risk Factors

With regard to IPV, the World Health Organization (WHO) released a list of factors associated with a man's risk for abusing his partner (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). These factors should not be considered complete as many other factors have been studied, but are not listed here.

World Health Organization Factors Associated With a Man's Risk for Abusing His Partner

Individual Factors	Relationship Factors	Community Factors	Societal Factors
• Young age • Heavy drinking • Depression • Personality disorders • Low academic achievement • Low income • Witnessing or experiencing violence as a child	• Marital conflict • Marital instability • Male dominance in the family • Economic stress • Poor family functioning	• Weak community sanctions against domestic violence • Poverty • Low social capital	• Traditional gender norms • Social norms supportive of violence

With regard to SV, the World Health Organization published a list of factors increasing men's risk of committing rape (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). The research on risk factors for SV and IPV is heavily biased towards offenders who have been convicted of a crime and/or male college students who have been studied largely in the U.S. Therefore, these factors should also be interpreted with caution.

World Health Organization Factors Increasing Men's Risk of Committing Rape

Individual Factors	Relationship Factors	Community Factors	Societal Factors
• Alcohol and drug use • Coercive sexual fantasies and other attitudes and beliefs supportive of sexual violence • Impulsive and antisocial tendencies • Preference for impersonal sex • Hostility towards women • History of sexual abuse as a child • Witnessed family violence as a child	• Associate with sexually aggressive and delinquent peers • Family environment characterized by physical violence and few resources • Strongly patriarchal relationship or family environment • Emotionally unsupportive family environment • Family honor considered more important than the health and safety of the victim	• Poverty, mediated through forms of crisis of male identity • Lack of employment opportunities • Lack of institutional support from police and judicial system • General tolerance of sexual assault within community • Weak community sanctions against perpetrators of sexual violence	• Societal norms supportive of sexual violence • Societal norms supportive of male superiority and sexual entitlement • Weak laws and policies related to sexual violence • Weak laws and policies related to gender equality • High levels of crime and violence

When multiple risk factors are combined, the risk for IPV and SV can increase dramatically. This was demonstrated by a group of researchers who studied sexual violence against dating partners on college campuses (Schwartz, DeKeseredy, Tait, & Alvi, 2001). They found that college men's level of drinking behavior (individual level) was a powerful predictor of their likelihood of perpetrating sexual violence against a dating partner (in other words, men who drank more were more likely to perpetrate). They also found that college men with male peers who endorsed or encouraged them to abuse women under certain circumstances (relationship level) had a higher level of self-reported sexual violence. However, the most striking finding was the combined effect of male drinking behavior and peer support of abusive behavior--male undergraduates who drank two or more times per week, who also had friends that provided peer support for both emotional and physical violence against a partner, were nine times more likely to commit sexual violence than men who did not report those characteristics. This is an example of how an individual level risk factor (drinking) interacts with a relationship level risk factor (association with male peers that endorse the abuse of women) to significantly increase a man's risk for perpetration of SV. It is important to note that community and societal contexts may have also contributed to the risk of perpetration in this study.

Protective Factors

Less is known about protective factors for SV and/or IPV. However, the *status of women* and *collective efficacy* are two potential protective factors that are being explored in the IPV and SV literatures.

The **status of women** in society has been proposed as a possible protective factor for both SV and IPV. The status of women is usually defined as the level of equality between men and women in areas like economics, employment, education, and legal status. One way to obtain information about the status of women in your state is a report published every two years by the Institute for Women's Policy Research (IWPR, 2004). This report provides composite indexes of data for 5 different domains: political participation, employment and earnings, social and economic autonomy, reproductive rights, and health and wellbeing. In addition to producing a report for each state, the IWPR published a manual with information about how to develop a county level index on the status of women (Werschkul, Gault, & Hartmann, 2004).

The relationship between status of women and IPV and SV is complex. According to one feminist theory, higher levels of equality should protect against SV and IPV. However, some studies have shown the opposite effect. Some authors have suggested that initially, changes in women's status lead to increases in SV and IPV (a "backlash" effect) but over time higher status is associated with lower levels of IPV and SV (Whaley, 2001). Other authors have suggested that status of women may have different effects depending on factors like race or local culture (Eschholz & Vieraitis, 2004; Pridemore & Freilitch, 2005). You may find it useful to look at status of women in your state or community as a potential protective factor, but keep in mind that higher status of women does not necessarily mean lower levels of IPV and/or SV. Appendix C includes information about how to assess the Status of Women at state and local levels. Using methods like interviews and focus groups with people in your community could help you understand how the status of women might relate to SV and/or IPV in your community.

Collective efficacy is defined as the degree to which a community is able to effectively mobilize to regulate local crime (Sampson, Raudenbush, & Earls, 1997). Collective efficacy is thought to be related to the number and quality of relationship networks and level of participation in community-based organizations among community residents. One researcher found that neighborhoods with higher levels of collective efficacy had lower intimate homicide rates and non-lethal partner violence (Browning, 2002). Items used to measure collective efficacy are included in the list of tools for understanding IPV and/or SV in Appendix C.

Another potential avenue for promoting health and well-being is **positive youth development**, which aims to develop individual and environmental assets among youth. Research suggests that positive youth development is associated with positive short and long-term outcomes for youth (Catalano, Berglund, Ryan, Lonczk, & Hawkins, 2002). The Search Institute's 40 Developmental Assets is a promising framework for

promoting positive youth development. The 40 Developmental Assets consist of 20 internal assets (e.g., achievement motivation) and 20 external assets (e.g., family support). A list of the 40 Developmental Assets are included on the next page. You will notice when you review the assets that they include individual level characteristics, as well as relationship and community level characteristics, which are considered the important building blocks of healthy youth development. Therefore, the 40 Developmental Assets are consistent with the social-ecological model that is central to the public health approach to prevention.

Research has shown that children who possess a higher number of the 40 Developmental Assets are more likely to experience positive outcomes such as school achievement and less likely to experience negative outcomes such as drug abuse, violence, and early sexual activity (Fisher, Imm, Chinman, & Wandersman, 2006). Research has not yet demonstrated that the 40 Developmental Assets are protective factors specifically against IPV and/or SV perpetration, however, there is a theoretical basis for implementing strategies that promote positive youth development as a means to reduce the risk of IPV and/or SV among youth. Specifically, we know that negative behaviors and positive behaviors among youth tend to cluster together and we know that assets are associated with other positive behaviors, so we can hypothesize that youth that have more assets are less likely to engage in SV and/or IPV perpetration. Also, promoting positive youth development is consistent with prevention literature that encourages us to promote health and well-being, rather than simply trying to avoid problems. If you decide to explore the 40 Developmental Assets among youth in your community, you can purchase surveys developed by the Search Institute that assess the number of assets possessed by individual youth. The website for the Search Institute is listed at the end of this chapter.

40 Developmental Assets® for Adolescents (ages 12 to 18)

Search Institute® has identified the following building blocks of healthy development—known as Developmental Assets®—that help young people grow up healthy, caring, and responsible.

EXTERNAL ASSETS

Support

1. Family support—Family life provides high levels of love and support.
2. Positive family communication—Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.
3. Other adult relationships—Young person receives support from three or more nonparent adults.
4. Caring neighborhood—Young person experiences caring neighbors.
5. Caring school climate—School provides a caring, encouraging environment.
6. Parent involvement in schooling—Parent(s) are actively involved in helping young person succeed in school.

Empowerment

7. Community values youth—Young person perceives that adults in the community value youth.
8. Youth as resources—Young people are given useful roles in the community.
9. Service to others—Young person serves in the community one hour or more per week.
10. Safety—Young person feels safe at home, school, and in the neighborhood.

Boundaries & Expectations

11. Family boundaries—Family has clear rules and consequences and monitors the young person's whereabouts.
12. School boundaries—School provides clear rules and consequences.
13. Neighborhood boundaries—Neighbors take responsibility for monitoring young people's behavior.
14. Adult role models—Parent(s) and other adults model positive, responsible behavior.
15. Positive peer influence—Young person's best friends model responsible behavior.
16. High expectations—Both parent(s) and teachers encourage the young person to do well.

Constructive Use of Time

17. Creative activities—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
18. Youth programs—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
19. Religious community—Young person spends one or more hours per week in activities in a religious institution.
20. Time at home—Young person is out with friends "with nothing special to do" two or fewer nights per week.

INTERNAL ASSETS

Commitment to Learning

21. Achievement motivation—Young person is motivated to do well in school.
22. School engagement—Young person is actively engaged in learning.
23. Homework—Young person reports doing at least one hour of homework every school day.
24. Bonding to school—Young person cares about her or his school.
25. Reading for pleasure—Young person reads for pleasure three or more hours per week.

Positive Values

26. Caring—Young person places high value on helping other people.
27. Equality and social justice—Young person places high value on promoting equality and reducing hunger and poverty.
28. Integrity—Young person acts on convictions and stands up for her or his beliefs.
29. Honesty—Young person "tells the truth even when it is not easy."
30. Responsibility—Young person accepts and takes personal responsibility.
31. Restraint—Young person believes it is important not to be sexually active or to use alcohol or other drugs.

Social Competencies

32. Planning and decision making—Young person knows how to plan ahead and make choices.
33. Interpersonal competence—Young person has empathy, sensitivity, and friendship skills.
34. Cultural competence—Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. Resistance skills—Young person can resist negative peer pressure and dangerous situations.
36. Peaceful conflict resolution—Young person seeks to resolve conflict nonviolently.

Positive Identity

37. Personal power—Young person feels he or she has control over "things that happen to me."
38. Self-esteem—Young person reports having a high self-esteem.
39. Sense of purpose—Young person reports that "my life has a purpose."
40. Positive view of personal future—Young person is optimistic about her or his personal future.

Using Existing Data to Learn about Risk and Protective Factors

Most existing information about risk and protective factors comes from research studies (some of which has been briefly summarized here for you). There are very few existing data sources at state and local levels about risk and protective factors for IPV and/or SV. One source that is available in some states is the Youth Risk Behaviors Surveillance System described on p. 39. Another source is the Institute for Women's Policy Research which publishes a report about the status of women by state every two years (Institute for Women's Policy Research, 2004).

Other information about risk and protective factors can be calculated fairly easily using data from your community profile. For example, your community or state profile probably includes information on poverty and employment which can provide some information about community-level risk factors. Some communities also collect information on adolescent well-being, some of which may be relevant the risk and protective factors discussed above.

Remember, you are not being asked to discover or test new risk and protective factors of IPV and/or SV perpetration as part of your local or state planning process. Just as it would be unnecessary for every community in the U.S. to assess whether smoking causes cancer; your needs assessment does not need to confirm that certain gender norms are associated with IPV and SV. Rather your needs assessment should focus on examining how gender norms play out and are maintained within your particular state or community. For instance, gender norms in a rural county in Montana may look different than gender norms in The Bronx in New York City. Likewise, reinforcement for adhering to gender norms in a county in Montana may look different than reinforcement for adhering to gender norms in The Bronx in New York City.

Collecting New Data about Risk and Protective Factors

Once the available data on risk and protective factors has been gathered, your needs and resources assessment team should spend some time considering what can be learned from the current data, and how this information fits together with the data from your community or state profile and the data you have collected on magnitude of IPV and/or SV. Also think about where there are gaps in your knowledge about risk and protective factors, and identify which gaps are most important to address as a part of your needs and resources assessment.

Once you have identified the gaps in information on risk and protective factors in your state or community, you can begin looking for information to fill in those gaps. One way to do this is to collect new information about risk and protective factors within your community. You will need to know about risk and protective factors for both your universal and selected populations—however, you will probably want to focus the bulk of your data collection within your selected population since they are at greater risk for IPV and/or SV than the general population.

Measuring risk and protective factors at the local and state level can be challenging even with extensive resources and expertise. Therefore, states and local communities are not expected to do sophisticated data collection and data analysis about risk and protective factors. One way to collect information on risk and protective factors is by surveys of convenience samples. Appendix C provides a list of tools and instruments that can be used to explore individual, relationship, and community level risk and protective factors.

States and communities can also explore risk and protective factors using qualitative methods of data collection such as key informant interviews, community forums, and focus groups. These types of approaches tap into the knowledge of members of your community (in other words, they reflect the EE principle of *community knowledge*). These community or state specific data can be supplemented with research data on risk and protective factors (consistent with the use of *evidence-based strategies*). The key is to be systematic and to collect information so that you make informed interpretations of the multiple sources of data available to you.

If you are working at the state level…

When working at the state level, it is most useful to focus on risk and protective factors at higher levels of the social-ecology (particularly the societal level). Risk and protective factors at the community and societal levels are more likely to be addressed by state level prevention strategies than are individual and relationship level risk factors.

Question #3: How can the SV and/or IPV primary prevention system capacity be improved to strengthen our community's or state's work to prevent SV and/or IPV?

The **SV and/or IPV primary prevention system** is the network of organizations and individuals that supports and expands the work of the 4-Step public health approach to addressing IPV and /or SV. This network is referred to as a prevention system due the responsibility to prevent IPV and/or SV not belonging to any singular organization or group and due to the network having a dynamic nature that is influenced by internal and external issues. The SV and/or IPV primary prevention system as a whole is greater than the sum of its parts. The SV and/or IPV primary prevention system is composed of many organizations and individuals, the relationships among these organizations and individuals, the leadership within and these organizations and the community or state, and the processes that link these organizations.

Specific elements of an SV and/or IPV primary prevention system are:

8. Leadership (recognized authority, legitimacy, accountability or influence)
9. Strategic Planning
10. Community Focus
11. Human Resources
12. System Operations (organizations, strategies, programs, and processes)
13. Information (data collection, analysis, and management)
14. Results/Outcomes Documented

More information on these specific elements of an SV and/or IPV primary prevention system will be available at the end of January 2007.

If you find that it is difficult to find answers to the questions regarding the magnitude of SV and/or IPV and risk/protective factors in your community or state because of a lack of reliable data sources in your community or state, then your NRWG has identified key elements of the SV and/or IPV primary prevention system that need strengthening. Other elements of your prevention system may have been identified in your community profile (i.e., Individual and community-level resources and assets, funding allocation to prevent SV and/or IPV**,** Individual and organizational prevention capacity). Identifying and defining the prevention system capacity in each community or state promotes *improvement, capacity building, community knowledge,* and *accountability.*

The IPV and/or SV primary prevention system capacity of a given state or community includes the capacity to assess and track the magnitude of SV and/or IPV among universal and selected populations over time as well as the risk and protective factors associated with the occurrence of IPV and/or SV. As you looked for answers to the first two questions in this section about magnitude and risk/protective factors, you probably noticed many of the limitations of the data sources that are currently available to you.

There are a variety of problems and needs you could uncover about existing data sources. For example, some states may administer the BRFSS, but not the accompanying IPV or SV modules. Other states may find a lack of consistency in the way law enforcement agencies and hospital emergency rooms define and track IPV and/or SV victimization. Service provider records may indicate a serious discrepancy in the magnitude of IPV and/or SV among certain groups as compared to national surveys that assess the magnitude of IPV and/or SV for that same group. You may find that your state lacks the partnership and collaboration necessary to track data about IPV and/or SV effectively, or perhaps there are key questions missing from surveys that are already collected systematically in your community.

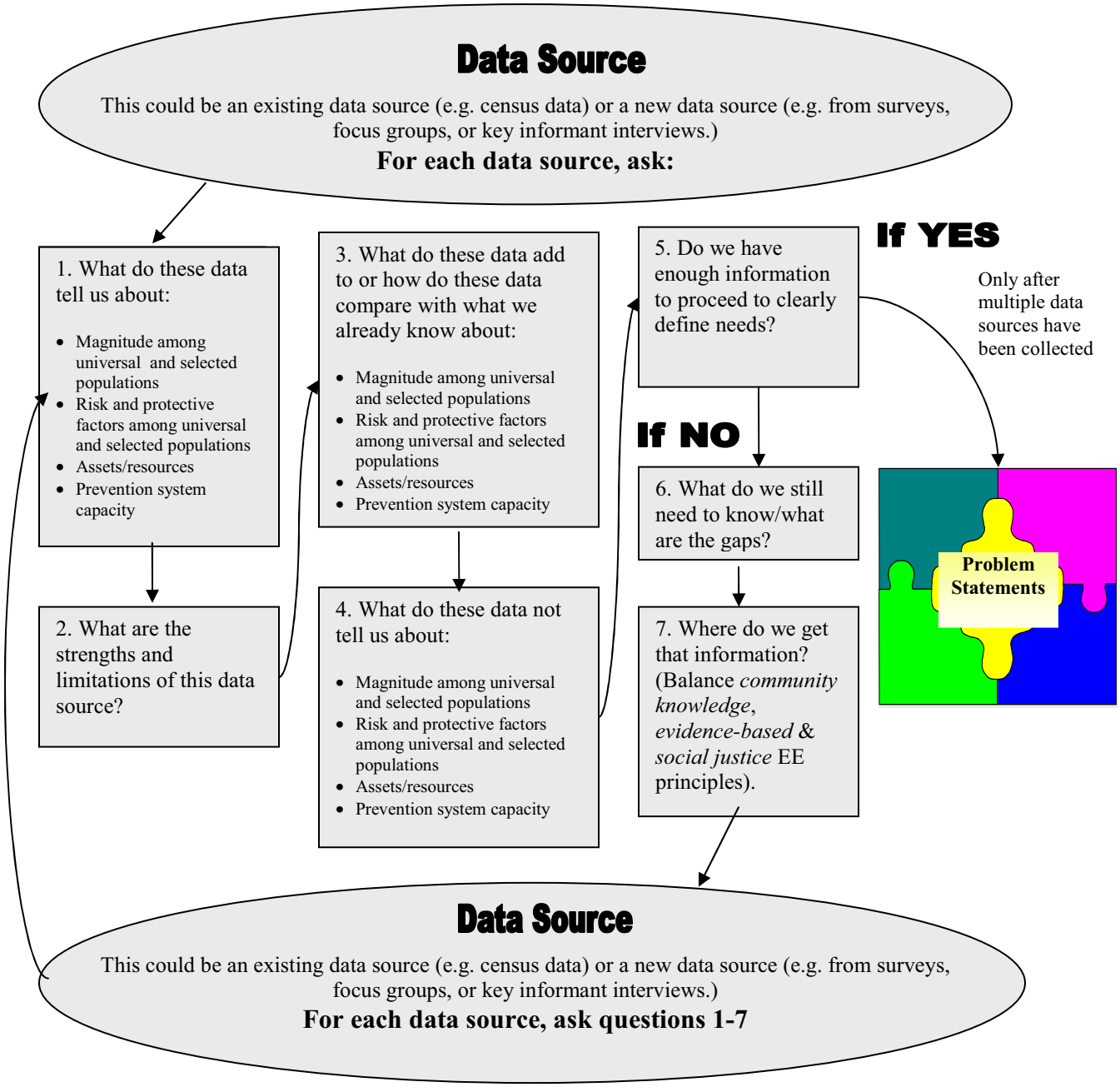
Whatever you discover about the limitations of existing data sources in your state or community while conducting your needs and resources assessment, those limitations are also data for your needs and resources assessment. Such limitations point to the need for improved data tracking systems and are an indicator of the current status of the IPV and/or SV primary prevention capacity (e.g., resources) within your state or community.

As most existing data sources have focused heavily on victimization rates and risk factors and only minimally on perpetration rates and risk factors, Needs and Resources Assessment Work Groups wishing to collect new data have an excellent opportunity to improve their state's or community's prevention system capacity by designing data collection strategies that provide greater information on perpetration rates and risk factors rather than victimization rates and risk factors.

You are encouraged to identify and prioritize problems that call for more systematic, reliable data tracking methods as part of your prevention plan. Later, you will develop goals and strategies to address these needs. Such strategies may not help you in the short term in completing your needs and resources assessment, but in the long term it can help you evaluate the strategies you choose and can help you update your needs and resources assessment in the future.

How to Think Critically About Data

As you look for answers to the three questions to understand IPV and/or SV in your community or state, you can refer to the figure on this page to remind you of the key considerations to thinking critically about data. You can use or adapt the *How to Think Critically about Data Worksheet* on the next page to record your team's responses to the various questions.



How to Think Critically About Data Worksheet

Data Source: _____

What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	
What does this data source tell us about risk and protective factors among universal and selected populations?	
What does this data source tell us about assets / resources?	
What are the strengths of this data source?	
What are the limitations of this data source (e.g. who was left out, how was data collected)?	
How does the information from this data source compare with other data sources?	
Could this data source be improved to provide more useful information in the future? If so, how?	
Do we have enough information to write clear problem statements?	
If no, what other information do we need?	
Where can we find that information?	

Bringing It All Together: Summarizing What You Learned

At this point, the NRWG has completed a community or state profile, reviewed existing data sources regarding IPV and/or SV in your community or state, and collected new data as appropriate. What the NRWG has learned should now be summarized into a Needs and Resources Report for review and comment by the entire GTO Planning Team and other stakeholders as appropriate. This report should summarize what has been learned and any conclusions reached regarding the community or state and SV and/or IPV within the community or state. While this report may contain conclusions, any prioritization of needs or development of goals should be delayed for GTO Step 2 when all members of the GTO Planning Team can participate in prioritization activities. The report presented to the GTO Planning Team for review and comment should be open to modification/editing based on feedback received.

Once the GTO Planning Team approves the Needs and Resources Report, the GTO Planning Team as a whole can move onto GTO Step 2 – Goals.

Two common questions regard the Needs and Resources Report are:

1. How should state-level reports inform local-level reports?
2. How should local-level reports inform state-level reports?

The answer to these questions is that each level should inform the other level, but not limit what the other level does. Recognizing that each local community is unique, local-level needs and resources assessments should be based on knowledge and data drawn from within each local community, thus revealing problems that may or may not be similar to state level problems. Therefore, local level GTO Planning Teams should ***not*** just assume that state-level reports take their unique needs into consideration or should they just adopt state-level reports as their own. Doing so would miss the point of conducting a community-level needs and resources assessment.

Some local planning groups may think that their reports should align with state level reports, especially if they believe that their funding is based on whether they address state priority problems. Such thinking could prevent local communities from fully engaging in their own needs and resources assessment process. Therefore, it is very important that state funders who are committed to the principles of *community ownership* and *community knowledge* encourage local communities to identify their own priority problems based on a systematic needs and resources assessment.

Each state-level GTO Planning Team will find a way to balance different state and local priorities. In working to achieve this balance, keep in mind that a strong local needs and resources assessment can provide a level of detailed information at the local level that is not usually obtained by a state level assessment. Therefore, local level needs and resources assessments can provide a wealth of *community knowledge* to state level GTO Planning Teams and can be an asset for developing both state and local plans to prevent SV and/or IPV.

Checklist for Step 1: Needs and Resources

Before moving onto Step 2, make sure you have …

- ❑ Formed a work group that has accepted the responsibility of conducting the needs and resources assessment and that represents the perspectives of diverse groups in your community/state.
- ❑ Defined the geographic area of interest for your needs and resources assessment.
- ❑ Developed a community or state profile or systematically reviewed an existing community or state profile that includes:
    - ❑ Demographic information for your community/state,
    - ❑ Conditions in your community/state,
    - ❑ Assets and resources (including existing prevention efforts) in your community/state.
- ❑ Examined data sources to estimate the magnitude of sexual violence and intimate partner violence among universal and selected populations in your community/state as described in your community profile
    - ❑ Using multiple data sources,
    - ❑ Considering the strengths and weaknesses of each data source.
- ❑ Examined relevant risk and protective factors for SV and/or IPV within universal and selected populations in your community/state
    - ❑ Using multiple data sources,
    - ❑ Considering the strengths and weaknesses of each data source.
- ❑ Identifed how the SV and/or IPV primary prevention system capacity can be strengthened.
- ❑ Written a Needs and Resources Report
- ❑ Reviewed a Needs and Resources Report with the GTO Planning Team and revised as appropriate
- ❑ Adopted the Needs and Resources Report

Other Resources for Needs and Resources Assessment

Minnesota Department of Health – Community Engagement Needs Assessment Fact Sheets
http://www.health.state.mn.us/communityeng/needs/needs.html
Fact Sheets provide instructions on how to conduct focus groups, key informant interviews, surveys, community forums and hearings, and community resource inventories.

The Asset-Based Community Development Institute
http://www.northwestern.edu/ipr/abcd.html
This organization produces resources and tools for communities to identify, nurture, and mobilize community assets.

The Community Tool Box
http://ctb.ku.edu/tools/en/chapter_1003.htm
The Tool Box provides over 6,000 pages of practical skill-building information on over 250 different topics. This link takes you to a chapter on “Assessing Community Needs and Resources”.

The Domestic Violence and Sexual Assault Data Resource Center
http://www.jrsa.org/dvsa-drc/index.html
This website provides information on how data about domestic violence and sexual assault are collected and used in the states.

The Search Institute
http://www.search-institute.org/
This organization identified 40 Developmental Assets which are positive experiences and personal qualities that young people need to grow up healthy, caring, and responsible.

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STEP 1

Appendix A: Sample State or Community Profile Tool

Sample State or Community Profile Tool
(Optional)

Community/State:_____

Source of data: _____ Year: _____

Community type: Urban ____ Rural ____ Suburban ____ Other _____ *(list by %?)*

Geographic size of description: _____

_____

Source of data: _____ Year: _____

Total population

Unemployment rate: Community _____ State _____

Per capita income: Community _____ State _____

Families below poverty level (%): Community _____ State _____

Source of data: _____ Year: _____

Age distribution in years

Community

Age	%	No.
<1		
1-14		
15-24		
25-64		
≥ 65		
Total population:		

State

Age	%	No.
<1		
1-14		
15-24		
25-64		
≥ 65		
Total population:		

Source of data: _____ Year: _____

Number of households, by household size

Community	**State**
1:	1:
2:	2:
3:	3:
4-5:	4-5:
6+:	6+:

Total number of households:

Source of data: _____ Year: _____

Annual household income

	Community		**State**	
Amount	%	No.	%	No.
< $15,000:				
$15,000-$24,999:				
$25,000-$49,999:				
$50,000+:				

Source of data: _____ Year: _____

Marital status*

	%	No.	No. by sex: Male	No. by sex: Female
Single:				
Married:				
Separated:				
Widowed:				
Divorced:				
Total:				

* Generally includes persons 18 years of age and older.

Source of data: _____ Year: _____

Racial / ethnic composition

	No.	%	% by sex Male	% by sex Female
White:				
Black:				
Hispanic*:				
American Indian+:				
Asian#:				
Other:				

* Includes both blacks and whites. +Or Alaska Native. #Or Pacific Islander.

Source of data: _____ Year: _____

Education

Number of person currently enrolled:

	Community	**State**
Elementary school	_____	_____
High school	_____	_____
Technical school	_____	_____
College	_____	_____

Educational achievement (% of adults who completed):

	Community	**State**
Elementary school plus 3 years high school	_____	_____
High school	_____	_____
Technical school	_____	_____
College: 1-3 years	_____	_____
4 years	_____	_____
≥ 5 years	_____	_____

Source of data: _____ Year: _____

STEP 1

Appendix B: Focus Group Tool

Focus Group Tool
(Optional)

COVER SHEET

Date (mo/da/yr) _____ Time: _____ to _____

Location_____

Facilitator _____

Recorder _____

Participant Characteristics

Participant	Age	Ethnicity	Gender	Current Relationship: Committed; Separated; Single
A				
B				
C				
D				
E				
F				
G				
H				
I				
J				
K				
L				
M				
Total #:				

Additional Notes about Participant Group:

Welcome and overview:

Good afternoon, and, thank you for coming. My name is _____ and I will be your discussion leader for today. This is _____ who will be recording the things that we will discuss.

- A "focus group" is like a discussion group where you share your ideas and opinions about a topic based on your own experiences in your family and community.

- I am not here to give information or to give you my opinions. My opinions don't matter. It is YOUR thoughts and opinions that matter. There are no right or wrong answers, because, **you** are the experts. You are the experts in YOUR opinions.

- You can disagree with each other respectively, and you can change your mind.

- Please, feel comfortable saying what you really think, and, how you really feel...remember, that is why we are here.

- The answers, or results, of all the focus group discussions will be compiled together for _____; We will not tell anyone who said what.

Present the purpose of the focus group:

- We are here today to talk about your thoughts about how to prevent intimate partner violence and/or sexual violence. [Put the definitions below on a poster or worksheet]

    - "Intimate partner" are people who are married, married but separated, formerly married, dating casually or in committed relationships, cohabiting, or former or current boyfriends/girlfriends (heterosexual or same-sex).

    - "Intimate partner violence" includes physical violence, sexual violence, threats of physical or sexual violence, and psychological/emotional abuse by a current or former intimate partner.

    - "Sexual violence" includes attempted or completed sex acts, abuse sexual contact, or non-contact sexual abuse without the victim's consent, or involving someone who is unable to consent or refuse.

    - "Primary prevention" is an effort or strategy to prevent a problem *before* it occurs the first time. We want to know what can be changed so that intimate partner violence and/or sexual violence is less likely to occur in our community or state.

Discuss procedure:

- _____ will be taking notes and tape recording the discussion so that I don't miss anything you have to say. Everything you say will be kept confidential. No one outside our group will know who said what. Let's all agree to keep what is said in this group, within our group.

- This is a group discussion; so, feel free to respond to me and to other members in the group without waiting to be called on. However, it is best if only one person talks at a time.

- This discussion will last about an hour and a half.

- It is very important that everyone is able to hear what is being said so I may interrupt someone briefly to ask you to speak louder.

- There is a lot to discuss, so, at times, I may ask us to move along to the next speaker or question.

Participant introduction/rapport building:

- Please print your first name in large, bold letters on this nametag and place it on the right (point to where your name tag is) so I can see it. It is okay to use a nickname or a pretend name!

- Now, let's start by everyone sharing his or her chosen name for today, and, your real age. Also, think of a word that best describes your mood or frame of mind today.

- We're going to go around the room so you can introduce yourself and the word you chose to describe your mood. Then, briefly explain why you selected that word.

- This will be the only time we will go around the room in this order. After we finish the introductions, feel free to jump in at any time without interrupting another speaker. The rest of us will be quiet when someone is speaking so we can hear everyone's opinion.

Potential Focus Group Questions for SV and/or IPV Prevention:

1. *How do you know that intimate partner violence and/or sexual violence goes on in your community?*

2. *Who in your community do you think is most affected by sexual violence and/or intimate partner violence?*

3. *Are certain areas in your community more affected by intimate partner violence and/or sexual violence than other areas?*

4. *Why do you think people commit sexual violence and/or intimate partner violence and/or sexual violence?*

5. *What would prevent someone from committing intimate partner violence and/or sexual violence?*

6. *What resources are in your community that could help prevent sexual violence and/or intimate partner violence?*

Clarification items (to use as needed during the "interview" section):

- **After each question in the interview, review the responses given then ask**, "Does anyone want to add an opinion on this?" "Does anyone see it differently?"

- **Other ideas for probing/clarifying questions**:
  "Tell me more about that."
  "What do you mean by that?"
  "Tell me an example of what you mean by that."
  "I'm not sure I understand what you mean. Help me out here."

- **For participants who don't say much**:
  Invite a quiet person to comment: "Do you have anything you would like to add?"
  "If there is anyone who hasn't spoken or said very much that would like to say something?"

Summary and Closure:

- Is there any other information that you think would be useful for me to know?

- We will put together a report about the information that you gave us. It will not include your name.

- Thank you very much for coming this afternoon. I appreciate your giving your time and your comments. Your opinions have been very helpful.

Data Analysis and Reporting:

The focus group data analysis and reporting process essentially involves four steps:

- Raw data collection (recording at the time of the groups)
- Description (writing initial summary ideas from the group recordings)
- Interpretation (identifying themes from all the ideas within a group and across multiple groups)
- Recommendation (developing a report about how the focus group themes can inform goal setting)

After the group, a descriptive summary record needs to be made of the main ideas that emerged from the group. These will help to shape the assessment of needs and resources in your community. Typically, in addition to ideas that the group has in direct response to the questions, other ideas emerge that are critically relevant to the topic.

After the ideas are described, they are reviewed to develop themes. It's best to have more than one person develop the themes. There may be various ways to interpret the themes and sharing perspectives will lead to greater enlightenment about the issues. Consider these processes:

- If you have adequate resources, make verbatim transcripts of the recorded sessions. Have two or more reviewers read the transcripts and make notes about main ideas that were raised.
- If you have fewer resources, have three people listen to the audiotapes together. Each person should make notes as he/she listens. About every five minutes or before a new question is asked, stop the tape and discuss emerging themes. Develop agreement.
- If you have limited time and staff resources, a careful review by the facilitator and recorder of the recorder's notes can reveal themes from the group discussion.

After your have a preliminary summary of themes, contact members of the focus group to see if the themes accurately reflect their ideas. Use their feedback to develop the final list of themes from the group.

If you conduct multiple groups, you will have several reports. You use a similar process to review the reports, identify common themes, note unique perspectives that do not cut across all groups, and develop a cumulative report for the groups.

Finally, the planning group should review the themes and decide how the themes can be used to inform the GTO process. The themes and the planning group's decisions become the report from the focus group(s).

STEP 1

Appendix C: Tools and Instruments for Collecting New Data to Understand Sexual Violence and/or Intimate Partner Violence

Tools and Instruments for Collecting New Data to Understand Sexual Violence and/or Intimate Partner Violence

Tools for Measuring Magnitude of IPV and/or SV*

Name of Instrument	Description	Reference	SV	IPV
Aggressive Sexual Behavior Inventory 20 items	Measures frequency of sexual aggression by college-age males against females in dating or other heterosocial-heterosexual situations.	Mosher, D. L. (1998). Aggressive Sexual Behavior Inventory. In Davis, C. et al. (Eds.) *Handbook of Sexually-Related Measures.* Thousand Oaks: Sage Publications.	✓	
Perpetration in Dating Relationships 18 items	Measures self-reported perpetration of physical violence within dating relationships among adolescents. Two items pertain to sexual violence.	Foshee, V. A., Linder, F., Bauman, K. E. et al. (1996). The Safe Dates Project: Theoretical basis, evaluation design, and selected baseline findings. *American Journal of Preventive Medicine, 12*(5), 39-47.	✓	✓
Psychological Maltreatment of Women Inventory (PMWI) 58 items	Measures psychological abuse of women by intimate male partners in the form of dominance-isolation and emotional-verbal abuse; male and female versions of the instrument are available.	Tolman, R. M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims, 4*(3), 159 – 177. http://sitemaker.umich.edu/pmwi/home		✓
Sexual Experiences Survey (SES) 10 items	Measures sexual aggression and victimization.	Koss, M. P., Gidycz, C. A., Wisniewski, N. (1987). The scope of rape: The incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Clinical and Consulting Psychology, 55*(2), 162-170.	✓	
The Revised Conflict Tactics Scales (CTS-2) 20 items	Measures the extent to which partners in dating, cohabitating, or marital relationships engage in psychological and physical attacks on each other and also their use of reasoning or negotiation to deal with conflicts.	Straus, M. A., Hamby, S. L., Warren, L. W. (1996). The revised conflict tactics scale (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17*(3), 283-316. www.wpspublish.com	✓	✓
Victimization in Dating Relationships 18 items	Measures self-reported victimization of physical violence within dating relationships among adolescents. Two items pertain to sexual violence.	Foshee, V. A., Linder, F., Bauman, K. E. et al. (1996). The Safe Dates Project: Theoretical basis, evaluation design, and selected baseline findings. *American Journal of Preventive Medicine, 12*(5), 39-47.	✓	✓

* Questions/items on each instrument may need to be modified to assess for lifetime prevalence, annual prevalence, and incidence.

Tools for Measuring Individual Level Risk and/or Protective Factors

Name of Instrument	Description	Reference	SV	IPV
Acceptance of Interpersonal Violence 6 items	Measures adults' attitudes condoning the use of force and coercion in relationships, particularly against women, as a means of solving problems or gaining compliance.	Burt, M. (1980). Cultural myths and supports for rape. *Journal of Personality and Social Psychology, 38*(2), 217-320.	✓	✓
Adversarial Sexual Beliefs 9 items	Measures self-reported beliefs among adults that male-female sexual relationships are exploitive, adversarial, manipulative, or coercive in nature.	Burt, M. (1980). Cultural myths and supports for rape. *Journal of Personality and Social Psychology, 38*(2), 217-320.	✓	
Anger Management Scale Short forms: 12 or 20 items Long form: 36 items	Measures adults' behaviors and cognitions that raise or lower anger in intimate partner relationships and impact subsequent levels of partner violence. Subscales include: calming strategies; self-awareness; negative attributions; and escalating strategies.	Stith, S. M. & Hamby, S.L. (2002). The anger management scale: Development and preliminary psychometric properties. *Violence and Victims, 17*(4), 383-399.		✓
Attitudes Toward Rape (ATR) questionnaire 32 items	Measures attitudes toward rape, rape victims, and rapists.	Field, H. S. (1978). Attitudes toward rape: A comparative analysis of police, rapists, crisis counselors, and citizens. *Journal of Personality and Social Psychology, 36,* 156-179.	✓	
Attitudes Toward Rape Victims Scale 25 items	Measures adults' favorable versus unfavorable attitudes toward rape victims including issues of blame, denigration, credibility, responsibility, deservingness, and trivialization.	Ward, C. (1998). The attitudes toward rape victims scale. *Psychology of Women Quarterly, 12*, 127-246.	✓	
Drug and Alcohol Use – Problem Behavior Frequency Scale 6 items	Measures adolescents' self-reported frequency of drug and alcohol use in the past 30 days.	Dahlberg, L. L., Toal, S. B., Swahn, M., Behrens, C. B. (2005). Measuring Violence-Related Attitudes, Behaviors, and Influences Among Youths: A Compendium of Assessment Tools, 2nd ed., Atlanta, GA: CDC.	✓	✓
Expagg Revised 40 items	Measures adults' instrumental reactions and expressive reactions to involvement in an aggressive event.	Archer, J. Haigh, A. M. (1997). Do beliefs about aggressive feelings and actions predict reported levels of aggression? *British Journal of Social Psychology, 36*(1), 83-106.	✓	✓
Gender-Role Conflict Scale (GRCS)	Measures gender-role conflicts in adult males' behaviors, feelings, and thoughts with four factors:	O'Neil, J. M., Helms, B. J., Gable, R. K., David, L., & Wrightsman, L. S. (1986).		

Tools for Measuring Individual Level Risk and/or Protective Factors

Name of Instrument	Description	Reference	SV	IPV
37 items	1) conflicts between work and family relations, 2) restrictive affectionate behavior between men, 3) restrictive emotionality, and 4) success, power, and competition.	Gender-role conflicts scale: College men's fear of femininity. *Sex Roles, 14*(5/6), 335-350.		✓
Hypergender Ideology Scale (HIS) 57 items	Measures adherence to extreme stereotypic gender beliefs in both men and women.	Hamburger, M. E., Hogben, M., McGowan, S., & Dawson, L. J. (1996). Assessing hypergender ideologies: Development and initial validation of a gender-neutral measure of adherence to extreme gender-role beliefs. *Journal of Research in Personality, 30*(2), 157-178.	✓	✓
Hypermasculinity Inventory 30 items	Measures adult males' masculine personality characteristics including calloused sexual attitudes; a conception of violence as manly; and a view of danger as exciting.	Mosher, D. L. & Sirkin, M. (1984). Measuring a macho personality constellation. *Journal of Research in Personality, 18*, 150-163.	✓	✓
Male Role Norms Inventory 58 items	Measures male sex role norms among adult males and females; includes 7 subscales: avoidance of femininity, homophobia, achievement/status, attitudes towards sex, restrictive emotionality; self-reliance and aggression.	Levant, R. F., Hirsch, L., Celentano, E., Cozza, T., Hill, S., MacEachern, M., Marty, N., & Schnedeker, J. (1992). The male role: An investigation of contemporary norms. *Journal of Medical Health Counseling*, *14,* 325-337.	✓	✓
Perceived Causes of Rape Scale (PCR) 32 items	Measures college-age students' beliefs about the causes of rape including 5 subscales: female precipitation, male sexuality, male hostility, male dominance, and society and socialization.	Cowan, G., & Quinton, W. (1997). Cognitive style and attitudinal correlates of the perceived causes of rape scale. *Psychology of Women Quarterly, 21,* 227-245.	✓	
Rape Myth Acceptance Scale (RMAS) 26 items	Measures adults' acceptance of rape myths defined as prejudicial, stereotyped, or false beliefs about rape, rape victims and rape perpetrators. 10 minute completion time.	Burt, M. (1980). Cultural myths and supports for rape. *Journal of Personality and Social Psychology, 38*(2), 217-320.	✓	
Rape Supportive Attitudes Scale 20 items	Measures adult males' hostile attitudes towards rape victims, including false beliefs about rape and rapists.	Lottes, I. L. (1991). Belief systems: Sexuality and rape. *Journal of Psychology & Human Sexuality, 4*(1), 37-59.	✓	
Revised Attitudes Toward Rape scale	Measures attitudes toward rape among college-aged students and adults including 7 subscales: stranger myth; victim blaming; false reports;	Harrison, P., Downes, J., Williams, M. (1991). Date and acquaintance rape: Perceptions and attitude change strategies.	✓	

Tools for Measuring Individual Level Risk and/or Protective Factors

Name of Instrument	Description	Reference	SV	IPV
25 items	sexual motivation; false "facts"; some women desire to be raped; you cannot be raped against your will; and seriousness of date and acquaintance rape.	*Journal of College Student Development*, *32*, 131-139.		
Sexual Beliefs Scale (SBS) Short form: 20 items Long form: 40 items	Measures five beliefs related to rape among adult males and females: token refusal; leading on justifies force; women like force; men should dominate; and no means stop.	Muehlenhard, C. and Felts, A. (1998). Sexual Beliefs Scale. In Davis, C. et al. (Eds.) *Handbook of Sexually-Related Measures.* Thousand Oaks: Sage Publications.	✓	
Sex-Role Egalitarianism Scale (SRES) 95 items	Measures attitudes toward the equality of men and women among adult males and females. Includes five subscales including marital roles; parental roles; employment roles; social-interpersonal-heterosexual roles; and educational roles.	King, L. A. & King, D. W. (1997). Sex-Role Egalitarianism Scale: Development, psychometric properties, and recommendations for future research. *Psychology of Women Quarterly, 21*, 71-87. www.sigmaassessmentsystems.com/assessments/sres.asp	✓	✓
Substance Abuse Subtle Screening Inventory-3 (The SASSI-3)	Brief and easily administered psychological screening measure that helps identify individuals who have a high probability of having a substance use disorder. Adult and adolescent versions are available.	Lazowski, L. E., Miller, F. G., Boye, M. W., Miller, G. A. (1998). Efficacy of the Substance Abuse Subtle Screening Inventory-3 (SASSI-3) in identifying substance dependence disorders in clinical settings. *Journal of Personality Assessment, 71*(1), 114-128. www.sassi.com/sassi/index.shtml	✓	✓

Tools that Measure Relationship Level Risk and/or Protective Factors

Name of Instrument	Description	Reference	SV	IPV
Male Peer Support 8 items	Measures perceived encouragement and support from male peers to engage in physical and verbal/emotional violence; and attachment to abusive peers who sexually assault women.	Schwartz, M. D., DeKeseredy, W. S., Tait, D., & Alvi, S. (2001). Male peer support and a feminist routine activities theory: Understanding sexual assault on the college campus. *Justice Quarterly, 18*(3), 623-649.	✓	✓
Norbeck Social Support Questionnaire 9 items	Measures adult respondents' perceived affect, affirmation, and aid for each significant person in their life. Number of members of their social network, duration of relationships, and frequency of contact are also reported.	Norbeck, J. S., Lindsey, A. M., Carrieri, V. L. (1981). The development of an instrument to measure social support. *Nursing Research*, *30*, 264-269. http://nurseweb.ucsf.edu/www/NSSQ-Instrument.pdf	✓	✓
Sarason Social Support Questionnaire (Short form) 6 items	Measures perceived availability of social support and quality of the support available among adults.	Sarason, I. G., Sarason, B. R., Shearin, E. N., & Pierce, G. R. (1987). A brief measure of social support: Practical and theoretical implications. *Journal of Personality and Social Psychology, 4*, 497-510. http://web.psych.washington.edu/research/sarason/	✓	✓
Ways of Coping Scales-Revised 50 items	Measures coping processes among adult partners/couples; 8 subscales include: positive reappraisal, planful problem-solving, escape-avoidance, accepting responsibility, seeking social support, self-controlling, distancing, and confrontive coping.	Folkman, S., Lazarus, R.S., Dunkel-Schetter, C., DeLongis, A. & Gruen, R.J. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology, 50*(5), 992-1003.		✓

Tools that Measure Community and/or Societal Level Risk and/or Protective Factors

Name of Instrument	Description	Reference	SV	IPV
Collective Efficacy - Chicago Neighborhood Study 10 items	Measures informal social control, willingness to intervene, and social cohesion in a neighborhood. Residents are asked about the likelihood that their neighbors can be counted on to intervene in various situations and the level of trust they feel for their neighbors.	Sampson, R. J., Raudenbush, S. W., Earls, F. (1997). Neighborhoods and violence crime: a multilevel study of collective efficacy. *Science, 277,* 918-924.		✓
Community-Level Non-Intervention Norms	Percent of residents (or sample of residents) in a neighborhood who report high levels of agreement with the statement "Fighting between friends or within families is nobody else's business."	Browning, C. R. (2002). The span of collective efficacy: Extending social disorganization theory to partner violence. *Journal of Marriage and Family, 64,* 833-850.	✓	✓
Concentrated Disadvantage	Based on combined percentages of such factors as neighborhood residents who are living below the poverty line, receiving public assistance, unemployed, under 18 years of age, and female-headed households.	Browning, C. R. (2002). The span of collective efficacy: Extending social disorganization theory to partner violence. *Journal of Marriage and Family, 64,* 833-850.	✓	✓
Neighborhood Disorganization – Rochester Youth Development Study 17 items	Measures adults' perceptions of crime, dilapidation, and disorganization in his/her neighborhood.	Thornberry, T. P., Krohn, M. D., Lizotte, A. J., Smith, C. A., & Tobin, K. (2003). *Gangs and delinquency in developmental perspective.* New York: Cambridge University Press.	✓	✓
Neighborhood Disorganization – Seattle Social Development Project 5 items	Measures students' perception of crime, fighting, physical deterioration, and safety in their communities.	Arthur, M. W., Hawkins, J. D., Pollard, J. A., Cataano, R. F., & Baglioni, A. J. (2002). Measuring risk and protective factors for substance use, delinquency, and other adolescent problem behaviors: the Communities that Care Youth survey. *Evaluation Review, 26*(6), 575-601.	✓	✓
Perceived Community Problems – Chicago Youth Development Study 14 items	Measures the extent to which youth and their caregivers perceive negative problems in their community such as crime, noise, vandalism, vacant lots, etc.	Dahlberg, L. L., Toal, S. B., Swahn, M., Behrens, C. B. (2005). Measuring Violence-Related Attitudes, Behaviors, and Influences Among Youths: A Compendium of Assessment Tools, 2nd ed., Atlanta, GA: Centers for Disease Control and Prevention.	✓	✓

Tools that Measure Community and/or Societal Level Risk and/or Protective Factors

Name of Instrument	Description	Reference	SV	IPV
Status of Women	Measures five indicators of the status of women at the state and county level including: political participation; employment & earnings; social and economic autonomy; reproductive rights; and health and well-being	Werschkul, M., Gault, B., & Hartmann, H. (2004). *Assessing the Status of Women at the County Level: A Manual for Researchers and Advocates* (IWPR No. R300). Washington, DC: Institute for Women's Policy Research	✓	✓
Residential Stability	Percent of residents within a neighborhood that had lived in their current home for at least 10 years (housing tenure) and the percentage of houses occupied by owners.	Browning, C. R. (2002). The span of collective efficacy: Extending social disorganization theory to partner violence. *Journal of Marriage and Family, 64,* 833-850.		

STEP 1

Appendix D: Process for Gathering and Interpreting Data for a Community or State Level Needs Assessment

Process for Gathering and Interpreting Data for a Community or State Level Needs Assessment

The table below provides a list of data gathering and analysis activities. For each activity listed, the table provides an explanation of how this data can be useful (i.e. why it is worthwhile to do this activity) and some questions to ask (which are intended to help guide critical thinking/analysis about the data in question). Decision points frame these steps and are intended to encourage asking whether there is "enough" data or if more data needs to be gathered. The last column provides a brief (and very simplified) example of how each of these activities might play out for a state team.

Activity	How this data can be useful	Questions to ask about the data	Example
Decision point 1: Start with the definition of IPV/SV being used by your group and specific areas of focus (e.g. focus on perpetration, the risk and protective factors framework). It is important to explicitly acknowledge how our understanding frames the way we think about data needs and the questions we ask.			
Look at national data on IPV/SV	• Provides estimates of incidence/prevalence at the national level, • Provides estimates of fatalities • Provides estimates of occurrences that are otherwise unreported (to police, health care, or victim's services), • May provide more detailed about types of violence • May provide information about risk and protective factors related to perpetration or victimization	• What does national data tell us about our state? What does it not tell us about our state? • What does this data source tell us about perpetration and victimization among universal and selected populations? • What does it not tell us, and what assumptions might be made based on this data? • What populations of interest are not represented in this data? • What does this data source suggest about risk and protective factors? • How was this data gathered? How was incidence/prevalence and occurrence estimated or defined?	Data from the National Violence Against Women Survey (conducted in 1998) found that 1.5% of women surveyed and 0.9% of men surveyed reported that they were physically assaulted or raped by a current or former intimate partner in the past year. This survey suggests that violence committed against women is more likely to have been committed by a partner than violence against men, and women are more likely to be injured and require medical care due to IPV than men are. The FBI Supplementary Homicide Report for 2004 indicated that 1,159 women and 385 men were killed by an intimate partner.
Look at state/community level data: • Collected nationally (e.g. FBI Uniform Crime Reports) • Collected at the state	• Can develop estimates of incidence/ prevalence in your state, but each source has limitations (e.g. providing information only on incidents reported to police). • May be possible to break down by	• What does this data source tell us about perpetration and victimization among universal and selected populations? • What does it not tell us, and what assumptions might be made based on	Your team reviewed data from a community-wide or statewide network of IPV hotlines. Data collected from these calls provide information on individuals who call for help, but little information on the perpetrator.

Activity	How this data can be useful	Questions to ask about the data	Example
level • Could also be collected from local sources and compiled (e.g. data from local domestic violence agencies and rape crisis centers)	race/ethnicity, but probably unable to look at other factors (e.g. sexual orientation, SES). Be careful not to use race/ethnicity for a proxy for other factors (e.g. SES, location/community).	this data? • What populations of interest are not represented in this data? • What does this data source suggest about risk and protective factors? • How was this data gathered? How was incidence estimated? • What assumptions about race/ethnicity might be made based upon the data available (e.g. has race or ethnicity been assumed to be the same thing as socioeconomic status)?	Another source of data is a compilation of IPV arrest records from across the community or state. This data set provides information about perpetrators, but only in cases where an incident was reported to police and an arrest took place.
Break down community or state level data by region or group (if applicable)	• If information is broken down by region or group, this data may help identify differences in incidence/prevalence across different regions of or groups in of your community or state. (Some data sources will not be possible to break down this way.)	• What does this data source tell us about differences across regions or groups within the community or state (if applicable)? • What are possible explanations for the differences between regions or groups? (e.g. lack of data collection in some areas, problems with data entry, etc.)	Data from IPV hotline in your state shows that 95% of calls to the hotline are from two metropolitan areas, and only 5% of calls are from rural areas. Arrest records show that 85% of SV arrests take place in the metropolitan areas.
Compare (or crosswalk) community/state/regional data with community/ state/regional profiles	• In theory, you can look at the incidence/prevalence of different groups within the state (or regions of the state). Lack of data (or the ability to look at specific populations of interest) may make it difficult to do this.	• How does information on IPV & SV fit with data from the state/regional profile? • What are possible explanations for discrepancies between the state/regional profile and data on IPV & SV? • What does this comparison tell us about the gaps in the existing data on IPV & SV?	Your state/region profile shows that 25% of the population of your state lives in rural areas, but data from SV hotline calls shows that only 5% of calls originate from rural areas, and only 15% of SV arrests take place in rural areas. Your state team identifies several possible reasons for these discrepancies: • SV may be lower in rural areas • There may be less awareness of the SV hotlines or other barriers to calls in rural areas (and thus, fewer calls) • There may be more reluctance to call the police in rural areas, or lower

Activity	How this data can be useful	Questions to ask about the data	Example
			likelihood that police officers make SV related arrests in these areas The latter two reasons suggest a need for more information about SV in rural areas of your state.
Decision Point 2: Identify gaps in the community or state data you have based on the crosswalk of the community/state/region profile and incidence/prevalence estimates by community/state/region. There will probably also be gaps based on data not collected (e.g. magnitude by sexual orientation, data on risk and protective factors)			
Look at existing data that can help to fill in the gaps. Examples might be: • Research on underrepresented populations • Research on risk and protective factors for IPV/SV • Special studies in your state	• May be able to extrapolate based on existing research and what is known about these populations in your state/region.	• What does the information from these studies tell us about our state? What does it not tell us about our state? • What does this information tell us about perpetration and victimization among universal and selected populations? What does it not tell us, and what assumptions might be made based on this information? • What populations of interest are not included? • What does this data source suggest about risk and protective factors? • How was this data gathered? How was incidence estimated?	Your team looks at research specific to IPV in rural areas. These studies suggest that women experiencing IPV in rural areas tend to be socially and geographically isolated. However, there are very few studies, and none have been conducted in your state's geographic region.
Decision Point 3: Assess where you are based on the available state data compiled and the research/special studies reviewed. Do you need more specific information on magnitude or risk and protective factors? If **no**, then go to the next decision point. If **yes**, what further information is needed?			
Collect additional data. Examples might be: • Interviews with experts who are members of or knowledgeable about the communities you need more information about. • Focus groups with community members.	• These methods can provide more in depth information about groups who are often underrepresented or unrepresented in other data sources. • These methods can provide information on risk and protective factors that is often is not included in other types of data collection.	• What can be learned from the methods used? • What are limitations of the methods used? • What does this data source suggest about risk and protective factors?	Your state team conducts focus group with men who have been convicted in the past year of misdemeanor IPV (prior to their entry in to a battering intervention program) in three rural communities to understand their perceptions of social and gender norms related to IPV. Your team also conducts separate focus

Activity	How this data can be useful	Questions to ask about the data	Example
• Surveys of specific groups you are interested in learning more about.			groups with women and men who have no history of IPV in these same three rural communities to understand their perceptions of social and gender norms related to IPV.
Identify data of interest is not currently collected, but could be collected. • Some data needs may be addressed quickly by adding questions to ongoing data collection efforts • Some data needs may take more time (either to develop new ways of collecting data or to implement changes to ongoing data collection) and may become part of your state prevention plan	• Working with state and local partners to improve existing data sources or implement new forms of data collection provides can improve data available for evaluation prevention strategies and assessing needs and resources in the future	• What will this data tell us about perpetration? What will it not tell us? • What populations of interest may not be included? How can we ensure we are able to reach these populations? • How can data about risk and protective factors be incorporated in the collection of this data?	Your team identifies questions that could be added to an existing state survey to provide additional information about SV in rural areas, including information on the risk and protective factors identified as problems in the interviews and focus groups conducted.
Decision Point 4: Based upon all data available, what is the magnitude of IPV/SV in your state among universal and selected populations? What are the risk and protective factors for IPV/SV among universal and selected populations?			